

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 546

CERTIFICATE OF DEATH

 09106
 Reg. Dist. No. 216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

U.S. Naval Hospital, Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State _____ County _____

City or town Washington, D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 3049 Foxhall Rd. N.W.
(If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

William Wallace ANDERSON Jr.

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6.(a) Single, married, widowed, or divorced

married6.(b) Name of husband or wife May Anderson

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.)

Nov 17, 1904

8. AGE:

Years

Months

Days

If less than one day

41915

hrs.

min.

9. Birthplace

Maryland

(Town, county, and state)

10. Usual occupation

U.S. Navy

11. Industry or business

FATHER

12. Name

William W. Anderson

13. Birthplace

S.C.

MOTHER

14. Maiden name

App'ia Kerfoot (dec)

15. Birthplace

Ind.

16. Informant

Mrs. May Anderson

Address

3049 Foxhall Rd. N.W. Wash., D.C.

17.

burial

(Burial, cremation, or removal. Which?)

Date thereof

9-4-46

(month) (day) (year)

Cemetery or crematory

National Arlington

Location

Arlington, Va.

18. Funeral director

W. W. Chambers Co.

Address

31st M St., NW, Wash., D.C.

19.

2 Sept

19

46Mary Charlotte Smith

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 2 Sept 19 46 at 9:10am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

3 Aug.19 46to 2 Sept.19 46and that I last saw him alive on 2 Sept. 19 46

Immediate cause of death

Respiratory failure

DURATION

Due to

Malignant Brain Tumor2 1/2 yrs

Due to

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Malignant Brain TumorDate of op. Feb. 1945

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

for E. N. Weaver
C. S. Mac Carty, Lt.(MC) USN

M. D. or other

Address NavHosp Bethesda, Md. Date signed 9-2-46

RECEIVED
SEP 7 1946
BUREAU V.E.

REC
SEP 7
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

09107 216
Reg. Dist. No.

1. PLACE OF DEATH: County... <u>Montgomery</u> City or town... <u>Bethesda (rural)</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? ... <u>13 days</u> Hospital, institution, or street address where death occurred: <u>USNH Bethesda, Md.</u> How long in hospital or institution? ... <u>13 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State... _____ County... _____ City or town... <u>Washington, D. C.</u> (If outside city or town limits, write RURAL and give nearest town) Street No... <u>3900 Connecticut Avenue, N.W.</u> (If rural, give LOCATION) 2.(a) If veteran, name war... _____			
3. (a) FULL NAME <u>ANDREWS, Charles Oscar, Senator</u>				3. (b) Social Security Number _____			
4. Sex <u>male</u>		5. Color or race <u>W-US</u>		6. (a) Single, married, widowed, or divorced <u>married</u>			
B. (b) Name of husband or wife <u>Mrs. Margaret S. Andrews</u>							
7. Birth date of deceased (mo., day, yr.) <u>March 7, 1877</u>							
8. AGE: Years <u>69</u> Months <u>6</u> Days <u>11</u> If less than one day _____ hrs. _____ min.		B. (c) If alive, give age _____ years					
9. Birthplace <u>Florida</u> (Town, county, and state) 10. Usual occupation <u>Senator</u>							
11. Industry or business FATHER 12. Name... <u>John Andrews</u> 13. Birthplace... <u>Ga.</u> MOTHER 14. Maiden name... <u>Mary Yaugh</u> 15. Birthplace... <u>Ala.</u>							
16. Informant <u>wife: Mrs. Margaret S. Andrews</u> Address <u>3900 Connecticut Avenue, N. W.</u> <u>Washington, D. C.</u>							
17. removal <u>9-18-46</u> (Burial, cremation, or removal. Which?) Date thereof (month) (day) (year) Cemetery or crematory... _____ Location... <u>Orlando, Florida</u> 18. Funeral director <u>Martin W. Hysong</u> Address <u>1300 N. St., N. W., Wash., D.C.</u>							
19. <u>18 Sept. 19 46</u> <u>Mary Charlotte Smith</u> (Date rec'd by registrar) Registrar							
MEDICAL CERTIFICATION 20. DATE OF DEATH ... <u>18 September 19 46</u> at <u>4:55 A.M.</u> 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>4 Sept. 19 46</u> to <u>18 Sept. 19 46</u> and that I last saw him <u>live on 18 Sept. 19 46</u> Immediate cause of death <u>Congestive heart failure</u> <u>Coronary heart disease</u> <u>arteriosclerotic</u> DURATION <u>3 hours</u> <u>4 years</u> Due to... _____ Due to... _____ Other conditions... _____ (Include pregnancy within 3 months of death) Major findings of operations... _____ Date of op. _____ Autopsy results... <u>NONE</u> PHYSICIAN: Please underline the cause to which death should be charged statistically.							
22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide... _____ Date of _____ Where did injury occur? _____ (City or town) (County) (State) Injured at home, farm, industry, public place (where?) _____ Means of injury _____ Injured at work? _____							
23. SIGNATURE <u>F. E. CHATARD, Comdr. M. D. or other USN</u> <u>USNH Bethesda, Md.</u> Address _____ Date signed <u>9-18-46</u>							

9/21/46

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SEP 24 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

940

09108

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH: *Montg. Co.*
 County *411 Silver Spring Ave*
 City or town *Silver Spring Md.*
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State *Md* County *Montgomery*
 City or town *Silver Spring*
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. *411 Silver Spring Ave.*
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME *Mary L. Andrews*

3. (b) Social Security Number

4. Sex *Female* 5. Color of face *White* 6. (a) Single, married, widowed, or divorced *Widow*
 6. (b) Name of husband or wife *Edgar J. Andrews*
 7. Birth date of deceased (mo., day, yr.) *Feb. 25 1868* 6. (c) If alive, give age years
 8. AGE: Years *78* Months Days If less than one day
 hrs. min.

9. Birthplace *Ind.* (Town, county, and state)
 10. Usual occupation *None*
 11. Industry or business
 12. Name *Anna A. Alderson*
 13. Birthplace *Ohio*
 14. Maiden name *Sarah Jane Coughill*
 15. Birthplace *Ohio*
 16. Informant *Mrs. Margaret L. Williams*
 Address *411 Silver Spring Ave. S.F. Md.*
 Relationship *Personal* Date thereof *9/12/46*

17. (Burial, cremation, or removal. Which?) *Burial* Date thereof *9/17/46*
 Cemetery or crematory *St. George Cemetery*
 Location *Washington D.C.*
 18. Funeral director *Cherry Chase Funeral Home*
 Address *5103 Pike Ave N.W.*

19. *Sept. 12* 19 *46* *Josephine M. Schaeffer*
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH *9/12* 19 *46*, at *6:30* A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from *Mar. 30* 19 *46* to *9/12* 19 *46*
 and that I last saw him alive on *9/10* 19 *46*
 Immediate cause of death *Coronary heart disease (acute attack)* DURATION *6 mo*
to my knowledge probably longer
 Due to
 Due to
 Other conditions *None*
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE *Joseph R. Jordan MD* M. D. or other
 Address *5412 Colo. Ave* Date signed *9/12/46*

RECEIVED

SEP 14 1946

BUREAU V. S.

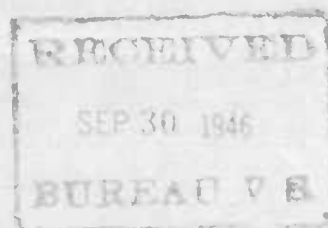
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✓

2411 N. Charlen St., Baltimore 1952

Reg. Dist. No. 216

1. PLACE OF DEATH: County <u>Montgomery</u> City or town <u>Bethesda (rural)</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? <u>11 days</u> Hospital, institution, or street address where death occurred: <u>US Naval Hospital, Bethesda, Md.</u> How long in hospital or institution? <u>11 days</u>				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>Md.</u> County <u>Wash.</u> City or town <u>Keedysville</u> (If outside city or town limits, write RURAL and give nearest town) Street No. _____ (If rural, give LOCATION) <u>✓</u> 2.(a) If veteran, name war _____			
3.(a) FULL NAME <u>BAKER, Gerald Eugene, S2c USN</u>				3.(b) Social Security Number _____			
4. Sex <u>male</u>		5. Color or race <u>W-US</u>		6.(a) Single, married, widowed, or divorced <u>single</u>		MEDICAL CERTIFICATION	
6.(b) Name of husband or wife _____				2D. DATE OF DEATH <u>23 Sept.</u> <u>1946</u> at <u>11:40A</u> N.			
7. Birth date of deceased (mo., day, yr.) <u>27 April 1927</u>				21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>12 Sept.</u> <u>1946</u> to <u>23 Sept.</u> <u>1946</u> and that I last saw him alive on <u>23 Sept.</u> <u>1946</u>			
8. AGE: Years <u>19</u> Months <u>4</u> Days <u>26</u>		If less than one day _____ hrs. _____ min.		Immediate cause of death <u>Respiratory failure</u>		DURATION <u>8 wks</u>	
8. Birthplace <u>Md.</u> (Town, county, and state)				Due to <u>Fracture 4th Cervical vertebrae</u>			
10. Usual occupation <u>Navy</u>				Due to _____			
11. Industry or business _____				Other conditions _____			
FATHER		12. Name <u>Fred L. Baker</u>		(Include pregnancy within 8 months of death)			
13. Birthplace <u>Md.</u>		Major findings of operations _____					
MOTHER		14. Maiden name <u>Clemmie Smith</u>		Date of op. _____			
15. Birthplace <u>Md.</u>		Autopsy results _____					
16. Informant <u>Mo: Mrs. Clemmie Baker</u>				PHYSICIAN: Please underline the cause to which death should be charged statistically.			
Address <u>Keedysville, Md.</u>				22. VIOLENCE: If death was due to external causes, fill in the following:			
17. <u>removal</u> (Burial, cremation, or removal. Which?)		Date thereof <u>9-24-46</u> (month) (day) (year)		Accident, suicide, or homicide _____ Date of _____			
Cemetery or crematory _____				Where did injury occur? <u>Spent Lake</u> (City or town) (County) (State)			
Location <u>W. W. Chambers</u>				Injured at home, farm, industry, public place (where?) <u>Swimming Pool</u>			
18. Funeral director _____				Means of injury <u>Hit on neck by falling board</u> Injured at work? _____			
Address <u>1400 Chapin St., N. W., Wash., D. C.</u>				E. N. WEAVER, Lt. (jg) USNR (MC)			
9-23 46 <u>Mary Charlotte Smith</u>				23. SIGNATURE _____ M. D. or other _____			
19. (Date rec'd by registrar)				Address <u>USNH Bethesda, Md.</u> Date signed <u>9-23-46</u>			
Registrar _____							



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MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:
 County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 168
 Hospital, institution, or street address where death occurred:
USNH, Bethesda, Md.
 How long in hospital or institution? 168

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Maryland County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1903 Montgomery Lane
 (If rural, give LOCATION)
 2(a) If veteran, name war... World War I

3. (a) FULL NAME
BANFIELD, Philip Edward VBP

3. (b) Social Security Number

4. Sex Male 5. Color or race White-US 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of ~~husband~~ wife Mary Ella Banfield
 7. Birth date of deceased (mo., day, yr.) 21 June 1893 6. (c) If alive, give age years
 8. AGE: Years 53 Months 3 Days 6 If less than one day hrs. min.

9. Birthplace Kentucky
 (Town, county, and state)
 10. Usual occupation Automobile Business
 11. Industry or business
 FATHER 12. Name William L. Banfield
 13. Birthplace Kentucky
 MOTHER 14. Maiden name Dale Clark
 15. Birthplace Kentucky

16. Informant Wife: Mrs. Mary Ella Banfield
 Address 1903 Montgomery Lane, Bethesda, Md.
 17. Burial Date thereof 9-30-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director Joseph Gawler's Sons Inc., R.S.
 Address 1750-1758 Penna. Ave. N.W.

19. 28, Sept. 19 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 27 September 19 46 at 3:50 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 12 April 19 46 to 27 Sept. 19 46
 and that I last saw him alive on 27 Sept. 19 46

Immediate cause of death
Bronchogenic Carcinoma 1 yr
 Due to
 Due to
 Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations

Carcinoma, bronchogenic rt. lung, with massive hemorrage from rt. pulmonary artery
 Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.
following operation

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of Injury Injured at work?

23. SIGNATURE Frank S. Ashburn, Lt. Cdr. (MC) USN
 M. D. or other
 Address USNH Bethesda, Md. Date signed 9-27-46

RECEIVED
OCT 9 1946
BUREAU V R

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (122-B)

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 11 yrs.

Hospital, institution, or street address where death occurred:

4504 Highland Ave. Bethesda, Md.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... Montg.City or town... Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 4504 Highland Ave.

(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Harrison D. Bennett

3. (b) Social Security Number

4. Sex

Male

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

Mar. 2, 1935

8. (c) If alive, give age

8. AGE:

Years

Months

Days

If less than one day

1160

hrs.

min.

9. Birthplace

Wash. D.C.
(Town, county, and state)

10. Usual occupation

Student

11. Industry or business

FATHER

12. Name

Harrison Bennett

13. Birthplace

St. Vincent Minn.

MOTHER

14. Maiden name

Ruth Tipton

15. Birthplace

Wash. D.C.

16. Informant

Mr. Harrison BennettAddress 4504 Highland Ave. Bethesda

17. (Burial, cremation, or removal. Which?)

Burial

Date thereof

9/4/46

Cemetery or crematory

Rock Creek Cem.

Location

Wash. D.C.

18. Funeral director

Wm. Reuben HumphreyAddress 1557 Wis. Ave. Bethesda, Md.

19. (Date rec'd by registrar)

9/319. 46Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 2 19. 46, at 6 50 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 20, 19. 46, to Sept 2 19. 46and that I last saw him alive on Sept 2 19. 46Immediate cause of death Cardiac

DURATION

Failure secondarytoIntestinal obstruction& low grade peritonitisDue tosecondary to ileo-sigmoid colon formegacolon

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations Intestinal obstruction& small peritoneal abscess

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE Brooks S. BrownAddress 1835 Eye St. N.W.Date signed 9/2/46

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

SEP 5 1946

BUREAU V S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 9324

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CERTIFICATE OF DEATH

★ Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Chevy Chase, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
5538 Wessling lane,
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Chevy Chase, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5538 Wessling Lane,
 (If rural, give LOCATION)
 2. (a) If veteran, name war

3. (a) FULL NAME

ISABELLE M. BRIGHTWELL

3. (b) Social Security Number

None

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
John A. Brightwell
 6. (b) Name of husband or wife
 6. (c) If alive, give age 62 years
 7. Birth date of deceased (mo., day, yr.) May 29, 1880
 8. AGE: Years 66 Months 3 Days 25 If less than one day
hrs. min.

9. Birthplace Washington, D. C.
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER 12. Name John F. Moore
 13. Birthplace Penna.

MOTHER 14. Maiden name Katherine Martin
 15. Birthplace Penna.

16. Informant J. A. Brightwell
 Address 5538 Wessling lane, Ch. Ch. Md

17. Burial 9/27/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Cedar Hill Cemetery
Maryland
 Location

18. Funeral director W. Reuben Thompson
 Address Bethesda, Maryland

19. 9/25 46 Wm E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 24 19 46, at 4:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug. 19 46, to Sept 24 19 46,
 and that I last saw h. 22 alive on Sept 22 19 46

Immediate cause of death Coronary Thrombosis DURATION 1 day
 Due to Arteriosclerotic heart disease 2 years
 Due to
 Other conditions Rheumatoid arthritis 10 years
 (Include pregnancy within 8 months of death)

Major findings of operations Date of op.

Autopsy results
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE Robert E. Walker M.D. M. D. or other
 Address 3323 Old Kent Rd Date signed 9/24/46
Wash. D.C.

MASSACHUSETTS DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

SEP 27 1946

BUREAU V.S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 97a

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

808 Langley Drive

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

Street No. 808 Langley Drive
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Adolph Brun

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced widower

6. (b) Name of husband or wife Mary Brun

7. Birth date of deceased (mo., day, yr.) Sept. 21, 1871

8. AGE: Years 75 Months 0 Days 8 If less than one day hrs. min.

9. Birthplace Germany
(Town, county, and state)

10. Usual occupation Woodworker

11. Industry or business

12. Name Joseph Brun

13. Birthplace Germany

14. Maiden name Unknown

15. Birthplace Germany

16. Informant Walter C Brun

Address 808 Langley Dr., S.S., Md.

17. Burial, cremation, or removal. Which? Burial Date thereof Sept 29, 1946
(month) (day) (year)

Cemetery or crematory Calvary

Location Arlington, Montgomery Co., Ohio

18. Funeral director Werner C. Humphrey

Address Silver Spring, Md.

19. Sept 29, 1946 Joseph K. Schaeff
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 29, 1946 at 10:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 2nd last to Sept. 29th last
and that I last saw him live on Sept. 29th last

Immediate cause of death

Coronary atherosclerosis

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide. Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Thos J. Brunkhart M.D.
Sup. Med. Exam.

M. D. or other

Address Washington Md. Date signed 9-29-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

69112

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED

OCT 2 1946

BUREAU

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 61

CERTIFICATE OF DEATH

091113

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg, Co,
County.....
Germantown, Md,
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
40 yrs
How long in above place of death?
Hospital, institution, or street address where death occurred:
.....
Now long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
Md County Montg
State.....
Germantown Md,
City or town.....
(If outside city or town limits, write RURAL and give nearest town)
Street No.....
(If rural, give LOCATION)
2. (a) If veteran, name war.....

3. (a) FULL NAME Mary Elizabeth Burns

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Widow
B. (b) Name of husband or wife Harry N Burns
6. (c) If alive, give age..... years
7. Birth date of deceased (mo., day, yr.) May 21, 1870
8. AGE: Years 76 Months 3 Days 25 If less than one day
1870 ..hrs.min.

9. Birthplace Maryland
(Town, county, and state)
House Wife
10. Usual occupation.....
11. Industry or business
12. Name Marian Waters
13. Birthplace Md
14. Maiden name Susan Watkins
15. Birthplace Md

16. Informant Mrs George Grims
Address Germantown Md,
17. Burial Date thereof 9/19/46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Salem Church Cemetery
Cedar Grove, Md,
Location.....
18. Funeral director Ernest C Gartner
Address Gaithersburg Md,
19. Sept 17 19 46 Abraham G. Cook
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 19 46 at 7:20 P. M
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 15 19 46 to Sept 16 19 46
and that I last saw him alive on Sept 15 19 46
Immediate cause of death.....
Cerebral Hemorrhage DURATION 1 mo
Due to Hypertension 2 yrs
Due to.....
Other conditions Diabetes 8 yrs
(Include pregnancy within 3 months of death)

Major findings of operations..... Date of op.....
Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?
23. SIGNATURE J. B. Burchard M.D. M. D. or other
Address Gaithersburg Md Date signed 9-17-46

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SEP 19 1946
BUREAU V.E.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 17-a

CERTIFICATE OF DEATH

09114
Reg. Dist. No. 216

1. PLACE OF DEATH:
County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 mon., 8 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 1 mon., 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Va. County Arlington
City or town Arlington
(If outside city or town limits, write RURAL and give nearest town)
Street No. 4826 S. 29th St.
(If rural, give LOCATION)
2.(a) If veteran, name war 2nd World War ✓

3.(a) FULL NAME CROUSE, John Darcie 3.(b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced married
6.(b) Name of husband or wife Mrs. Gladys E. Crouse
6.(c) If alive, give age years
7. Birth date of deceased (mo., day, yr.) 27 July 1917
8. AGE: Years 29 Months 1 Days 6 If less than one day hrs. min.

9. Birthplace Va.
(Town, county, and state)
10. Usual occupation veteran
11. Industry or business
12. Name John B. Crouse
13. Birthplace Va.
14. Maiden name Bessie Brown
15. Birthplace Va.

16. Informant wife: Mrs. Gladys E. Crouse
Address 4826 S. 29th St., Arlington, Va.
17. burial Date thereof 9-4-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Va.

18. Funeral director W. W. Chambers
Address 1400 Chapin St., N. W.
Mary Charlotte Smith
19. 9-3 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 3 September 1946 at 11:30 A.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 25 July 46 to 3 Sept. 46
and that I last saw him alive on 3 September 1946
Immediate cause of death Chronic Ischemic
ulcer with perforation DURATION

Due to
Due to
Other conditions acute & chronic
peritonitis
(Include pregnancy within 8 months of death)

Major findings of operations
Date of op.
Autopsy results as above
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Road Isrant Injured at work?
23. SIGNATURE R. N. GRANT, Comdr. (MC) USN
M. D. or other
Address USNH Bethesda, Md. Date signed 9-3-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9/14/46

RECEIVED

SEP 17 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (942)

CERTIFICATE OF DEATH

09115

★ Reg. Dist. No. 216

1. PLACE OF DEATH

County MontgomeryCity or town Wood Acres
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Wood Acres
(If outside city or town limits, write RURAL and give nearest town)Street No. 6005 - Wellborn Dr
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

LUCY SPEIDEN - CULVERWELL

3. (b) Social Security Number

4. Sex F 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed6. (b) Name of husband or wife J Frank

B. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Nov 22 - 18748. AGE: Years 72 Months _____ Days _____ It less than one day _____ hrs. _____ min.9. Birthplace Washington DC
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Edgar Speiden13. Birthplace Wash DC14. Maiden name Lucy Leadbeater15. Birthplace Alex VA16. Informant Thas S SpeidenAddress 6005 - Wellborn Dr17. Burial Date thereof Sep 27-46
(Burial, cremation, or removal, which?) (month) (day) (year)Cemetery or crematory GlenwoodLocation Wash DC18. Funeral director The S. H. Hume Co.Address 2901 - 14 - NW19. 9/23 19 46 Thas S Speiden
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23 19 46 at 3:30 P. M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 18 19 46 to Sept. 23 19 46and that I last saw her alive on September 23 19 46Immediate cause of death Coronary Thrombosis

DURATION

5 days

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE John A. Swartwout M.D. M. D. or otherAddress 4807 - 14th St. N.W. Date signed 9-23-46

RECEIVED

SEP 25 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 482

CERTIFICATE OF DEATH

Reg. Dist. No. 09116

216

1. PLACE OF DEATH:

County Montgomery

City or town Chevy Chase Maryland

(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 13 Years

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Chevy Chase

(If outside city or town limits, write RURAL and give nearest town)

Street No. 4612- Nottingham Drive

(If rural, give LOCATION)

2.(a) If veteran, name war No

3. (a) FULL NAME

LUELLA K. DAVIS

3. (b) Social Security Number

No

4. Sex Female 5. Color or race White 6.(a) Single, married, widowed, or divorced Widow

6.(b) Name of husband or wife William H. Davis

7. Birth date of deceased (mo., day, yr.) July 11, 1859

8. AGE: Years 87 Months Years Days less than one day hrs. min.

9. Birthplace Georgia (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business -

12. Name Georgia

13. Birthplace Georgia

14. Maiden name Nina Archer

15. Birthplace Georgia

16. Informant Mrs. Megnon G. Atchison

Address 4612-Nottingham Drive Ch.Ch. Md.

17. Burial Date thereof Sept. 11, 1946 (month) (day) (year)

Cemetery or crematory Rock Creek, Washington D.C.

Location Cherry Hill Cemetery

18. Funeral director Cherry Chase Funeral Home

Address 5103-Wisconsin Ave. N.W. Washington D.C.

19. 9/10 19 46 Wm E. Jones Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 9 19 46 at 11:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Aug 2 19 46 to Sept 9 19 46

and that I last saw him alive on Sept 7 19 46

Immediate cause of death Carcinoma of Right lower jaw

Due to Cerebral metastases

Other conditions arteriosclerosis

(Include pregnancy within 8 months of death)

Major findings of operations none

Antopsy results none

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide none Date of none

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

Signature W. T. Jones M. D. or other

Address 546 Maple Ridge Rd. Date signed 9-10-46

Bethesda, Md

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

ED
SEP 11 1946
BUREAU V.S.
RECEIVED
SEP 11 1946
BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (93-1)

CERTIFICATE OF DEATH

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MONTGOMERYCity or town SILVER SPRING
(If outside city or town limits, write RURAL and give nearest town)Now long in above place of death? 7 MONTHS

Hospital, institution, or street address where death occurred:

MRS. MELTON'S REST HOME 9508 BILLMANE DRIVEHow long in hospital or institution? 7 MONTHS

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State VA County NORTH UMBERLANDCity or town LODGE
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D.
(If rural, give LOCATION)2.(a) If veteran, name war NONE ✓

3. (a) FULL NAME

MRS. ROSA DAWSON

3. (b) Social Security Number

NONE

4. Sex

FEMALE

5. Color or race

WHITE

6. (a) Single, married, widowed, or divorced

WIDOWED6. (b) Name of husband or wife EVERETT EDWARD DAWSON

B. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) MARCH 17 1872

8. AGE: Years Months Days If less than one day

7465

..... hrs. min.

9. Birthplace

VIRGINIA
(Town, county, and state)10. Usual occupation HOUSE WIFE

11. Industry or business

12. Name WILLIAM H. REYNOLDS13. Birthplace VIRGINIA14. Maiden name ANN RICHARDSON15. Birthplace VIRGINIA16. Informant MRS. FLOSSIE KILLIANAddress 1440 COLUMBIA RD. NW17. BURIAL(Burial, cremation, or removal, Which?) Date thereof SEPT 25 1946
(month) (day) (year)Cemetery or crematory HENDERSON M.E. CH. NORTH UMBERLANDLocation COUNTY VA.18. Funeral director J. William Lewis SonAddress 309 - 4th St NE Washington DC19. 9/22 46(Date rec'd by registrar) Registrar Amanda Rozema

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-46 19..... at 7:05 a.m.I CERTIFY that death occurred on the date above stated: that I attended deceased from 9-20-46 19..... to 19.....and that I last saw her alive on 9-20-46 19.....

Immediate cause of death..... DURATION

Cardiac StimulationDue to Intersclectic Heart Disease

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dean W. Harding MDAddress 113 Carroll St Date signed 9-22-46

*De Harding
7607 Route 200
apt 202*

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SEP 27 1945
BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 462 A

CERTIFICATE OF DEATH

09120 223
Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 22 days

Hospital, institution, or street address where death occurred:

Washington Sanatorium and HospitalHow long in hospital or institution? 22 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State..... County.....

City or town Havana, Cuba
(If outside city or town limits, write RURAL and give nearest town)Street No. Avenida de Belgica No. 18 Alturas de
(If rural, give LOCATION) Almendares

2.(a) If veteran, name war.....

3. (a) FULL NAME

Dominguez, Mr. Placido M.

3. (b) Social Security Number

4. Sex

Male

5. Color of race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Mrs. Kathryn Dominguez

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) May 29, 19818. AGE: Years Months Days If less than one day
65 3 11 2 hrs. 45 min.9. Birthplace Havana, Cuba
(Town, county, and state)10. Usual occupation Ex-Diplomat

11. Industry or business

12. Name ?13. Birthplace ?14. Maiden name ?15. Birthplace ?16. Informant Washington Sanatorium and HospitalAddress Takoma Park, Maryland17. Burial Date thereof Sept. 11, 1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory St. Marie's Catholic CemeteryLocation Med. Dr.18. Funeral director J. Arthur WintersAddress 254 - ...19. Sept 9 19 46

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 9 19 46 at 2:45 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

August 18 19 46 to Sept. 9 19 46and that I last saw him/her alive on Sept. 8 19 46Immediate cause of death PolyarthritisOld adhesive peritonitisGastric CancerDue to Bilateral PyelonephritisBilateral urinary calculiDue to diverticulAt Passer Recaps withOther conditions Osteomyelitis of Lumbar 3 & 4

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.....

Autopsy results As above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE De Val K. M. M. M. M.Address 504 ...Date signed 9-9-46

M. D. or other

M.D.

RECEIVED

SEP 14 1916

BUREAU V. M.

Permanently

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for change of age of deceased is shown on
MARYLAND STATE DEPARTMENT OF HEALTH
 2411 N. Charles St., Baltimore (742)
FILM No. I 07 OCT 8 1946 **CERTIFICATE OF DEATH**

09119
 Reg. Dist. No. 218

1. PLACE OF DEATH:
 County Montgomery
 City or town Baithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death?
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Baithsburg
 (If outside city or town limits, write RURAL and give nearest town)
 Street No.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Lucy L. Dorsey

3. (b) Social Security Number

none

4. Sex Female **5. Color or race** Colored **6. (a) Single, married, widowed, or divorced** Widowed
6. (b) Name of husband or wife
7. Birth date of deceased (mo., day, yr.) Oct. 1882 **6. (c) If alive, give age** 1882 years
8. AGE: Years 63 Months 64 Days 64 If less than one day hrs. min.

9. Birthplace Lawsonsville, Md.
 (Town, county, and state)
10. Usual occupation Housekeeper
11. Industry or business Alfred Scott
12. Name Manland
13. Birthplace Sarah
14. Maiden name Maryland
15. Birthplace

16. Informant Nathan Duvall
 Address Baithsburg, Md.
17. Buried Emory Grove
 (Burial, cremation, or removal. Which?) Date thereof Sept 24/1946
 (month) (day) (year)
 Cemetery or crematory Emory Grove, Md
 Location Robert L. Snowden
19. Funeral director Rockville, Md.
 Address

19. Sept 24 1946 Abunda H. Cooke
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 20, 1946 at 7 P.M.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept 19 1946 to Sept 19 1946
 and that I last saw him 4 alive on Sept 19 1946
Immediate cause of death Coronary thrombosis
DURATION

Due to same
Due to
Other conditions
 (Include pregnancy within 3 months of death)

Major findings of operations
 Date of op.
Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide. Date of
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?

23. SIGNATURE M. D. or other
 Address Baithsburg Date signed Sept 23/46

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SEP 26 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09121

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 30 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 30 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Md. County Bethesda
 City or town Catonsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 16 Kenwood Avenue
 (If rural, give LOCATION) ☒
 2. (a) If veteran, name war

3. (a) FULL NAME

DUGAN, Ferdinand Chatard, Lt.Cdr. USNR Ret.Inact.

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife Mrs. Mary Dugan

7. Birth date of deceased (mo., day, yr.) July 10, 1901 6. (c) If alive, give age years

8. AGE: Years 45 Months 1 Days 24 It less than one day hrs. min.

9. Birthplace Md.
 (Town, county, and state)

10. Usual occupation Ex Navy

11. Industry or business

12. Name Ferdinand C. Dugan13. Birthplace Md. (dec.)14. Maiden name Melanie Boone15. Birthplace Md.16. Informant wife: Mrs. Mary DuganAddress 16 Kenwood Avenue, Catonsville, 28, Md.

17. burial Date thereof 9/17/46
 (Burial, cremation, or removal Which?) (month) (day) (year)

Cemetery or crematory Cathedral CemeteryLocation Baltimore, Md.18. Funeral director H. W. Mears & Sons H.W.M.Address 805 N. Calvert St., Baltimore, Md.

19. 9-1 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 4 Sept. 19 46 at 7:24A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 5 Aug. 19 46 to 4 Sept. 19 46 and that I last saw him alive on 4 Sept. 19 46

Immediate cause of death Melanoma, malignant with brain metastases
 DURATION 3 months

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Autopsy results Melanoma metastases to brain and lung
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE F. E. CHATARD, Comdr. (MC) USN
 M. D. other

Address USNH Bethesda, Md. Date signed 9-21-46

9/12/46

RECEIVED
SEP 13 1946
BUREAU V. B.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 31-2

CERTIFICATE OF DEATH

09118

Reg. Dist. No. 816

1. PLACE OF DEATH:
 County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 73 days
 Hospital, institution, or street address where death occurred:
Suburban Hospital
 How long in hospital or institution? 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State... Illinois County... Cook
 City or town... Chicago
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7156 Bennett Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war... ☒

3. (a) FULL NAME

Mrs. Rose Dyer

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 8. (b) Name of husband or wife... Harold W. Dyer
 8. (c) If alive, give age... years
 7. Birth date of deceased (mo., day, yr.) Aug. 1, 1883
 8. AGE: Years 63 Months 1 Days 20 If less than one day
 ...hrs. ...min.

9. Birthplace... Chicago, Ill.
 (Town, county, and state)
 10. Usual occupation... Housewife
 11. Industry or business
 12. Name... Frank Somers
 13. Birthplace... Chicago, Ill.
 14. Maiden name... Laura Nichols
 15. Birthplace... Chicago, Ill.

16. Informant... Mrs. J. H. Edmonston
 Address 4307 Lynnbrook Dr. Bethesda
 17. Cremation Date thereof... 9/21/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory... Cedar Hill Cemetery
Maryland
 Location... Wm Reuben Humphrey

18. Funeral director... Wm Reuben Humphrey
 Address Bethesda, Maryland
 19. 9/21 19 46 Wm E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... Sept 20 19 46 at 1:29 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/13 19 46 to 9/20 19 46
 and that I last saw him alive on 9/19/46 19 46
 Immediate cause of death... Acute cardiac decompensation
 DUE TO... Cardiovascular renal disease with severe hypertension
 DUE TO...
 Other conditions...
 (Include pregnancy within 3 months of death)

Major findings of operations... Date of op...
 Autopsy results...
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide... Date of...
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?)
 Means of injury Injured at work?
 23. SIGNATURE... Bruce T. Benjamin M.D.
 Address... Bethesda, Md. Date signed... 9/20/46

RECEIVED
SEP 24 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the changes MARYLAND STATE DEPARTMENT OF HEALTH
made on this certificate is shown on 2411 N. Charles St., Baltimore 466

FILM No. I 08 NOV - 7 1946

CERTIFICATE OF DEATH

09122
Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery County
City or town Cherry Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County Montgomery
City or town Cherry Chase, Md.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 6312 Conn. Ave. Cherry Chase, Md.
(If rural, give LOCATION)

2.(a) If veteran, name war W.W. I

3. (a) FULL NAME

William Wynthrop Eiken

3. (b) Social Security Number

4. Sex M 5. Color or race W 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife single

7. Birth date of

deceased (mo., day, yr.)

April 21 1893

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

53

37

hrs.

min.

9. Birthplace

Wash. D. C.
(Town, county, and state)

10. Usual occupation

Revenue Examiner U.S. Dept.

11. Industry or business

Claims Div. Civil Acct. Office

12. Name

James M. C. Kerley Eiken

13. Birthplace

PENNA.

14. Maiden name

AGNES H. STROBEL

15. Birthplace

WASH. D. C.

16. Informant

Miss LAURA LOUISE EIKEN

Address

6312 Conn. Ave. Cherry Chase, Md.

17. Burial

Burial

Date thereof

9-24-46

(Burial, cremation, or removal. Which?)

Cemetery or crematory

Arlington

Location

Arlington, Va.

18. Funeral director

Frank G. Gable, Inc.

Address

1756 Penna. Ave. N.W.

19. 9/21 1946

(Date rec'd by registrar)

Wm E. Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept. 21st

19 46, at

M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 2nd

19 42, to

Sept. 21st

19 46

and that I last saw him alive on

Sept. 28th

18 46

Immediate cause of death

leukemia

DURATION

Metastasis of stomach

4 liver

3 mos

Due to leukemia of stomach

for which he was

operated in May 1942

4 mos

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

J. B. Mynkoff, M.D.

M. D. or other

Address 1501 Eye Street

Date signed Sept 21/46

RECEIVED

SEP 24 1946

BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09123

Reg. Dist. No.

223

1. PLACE OF DEATH:

County Montgomery County
 City or town Takoma Park Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? eleven days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium & Hospital
 How long in hospital or institution? eleven

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Virginia County Arlington
 City or town Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2311 N. Burlington St
 (If rural, give LOCATION)
 2(a) If veteran, name war no ✓

3. (a) FULL NAME

John Wyckoff Fenton

3. (b) Social Security Number

4. Sex male 5. Color or race white 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mrs Anna Johnson Fenton
 6. (c) If alive, give age 55 years
 7. Birth date of deceased (mo., day, yr.) May 10 - 1888
 8. AGE: Years 58 Months 4 Days 7 If less than one day hrs. min.

8. Birthplace Washington DC
 (Town, county, and state)

10. Usual occupation Civil Engineer

11. Industry or business Maritime Commission

12. Name John Wyckoff Fenton

13. Birthplace New York City, N.Y.

14. Maiden name Elsie Steffen

15. Birthplace Homburg, Germany

16. Informant wife - Mrs Anna Fenton

Address 2311 N. Burlington St. Arlington Va

17. Removed Date thereof 9-17-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington DC

Location Plot 8 & Grave 60

18. Funeral director 2901-14th St NW

Address Sept-17 46

19. Sept-17 46 Registrar
 (Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1946 at 8:20 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from February 12 1946 to 9/16/46 1946

and that I last saw him alive on 9/16/46 1946

Immediate cause of death Carcinoma of the lungs (Squamous) DURATION mo

rib, pleura, etc

Due to Heart & lung

Due to Heart & lung

Other conditions Artery from

(Include pregnancy within 3 months of death)

Major findings of operations 0 Date of op. 0

Autopsy results 0

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following; 0

Accident, suicide, or homicide 0 Date of 0

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Dr. H. Johnson M. D. or other

Address 500 Indiana NW Date signed 9/17/46

RECEIVED

SEP 20 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 140

CERTIFICATE OF DEATH

Reg. Diat. No. 09124 118

1. PLACE OF DEATH:

County Montgomery
 City or town Coler Grove Rd. R.F.D. Rural
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Two weeks
 Hospital, institution, or street address where death occurred:
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Germanstown in R.R. R.F.D.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. _____
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

Rosie May Freeland

3.(b) Social Security Number

u

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female Col Widowed

8.(b) Name of husband or wife Irish Freeland7. Birth date of deceased (mo., day, yr.) Jan 6 - 1889 B.(c) If alive, give age _____ years

8. AGE: Years Months Days It less than one day
57 8 20 _____ hrs. _____ min.

9. Birthplace Montgomery Co. Md.
(Town, county, and state)10. Usual occupation Domestic11. Industry or business House12. Name Benedict F. Weiss13. Birthplace Clarksburg Md.14. Maiden name Elizab. Hutcheson15. Birthplace Montgomery Co. Md.16. Informant Ben WeissAddress Clarksburg Md.17. Rural Date thereof Sept 25 - 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rocky Hill John WesleyLocation Montgomery Co. Md.18. Funeral director Prof. W. BarkerAddress Clarksburg Md.19. 9/26/46 46 H. D. Bell
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 26 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. med. exam case

and that I last saw him _____ alive on _____ 19____

Immediate cause of death _____

Coronary occlusion

Due to _____

Due to _____

Other conditions hypertension

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank J. Brorhaug M.D.Clarksburg Md. M. D. or otherAddress Clarksburg Md. Date signed 9-26-46

DURATION

2 and 1/2 hrs.3 yrs.

RECEIVED

OCT 3 1946

BUREAU V.B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 550 +

09125

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 2 months, 25 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 2 months, 25 days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State N.Y. County _____
 City or town Huguenot Park, L.I.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 146 Kingdon Avenue
 (If rural, give LOCATION) ✓
 2.(a) If veteran, name war ★

3. (a) FULL NAME

FRICK, Richard Martin, PhM3c V-6 USNR

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced single
 6.(b) Name of husband or wife _____
 6.(c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) 4-27-25
 8. AGE: Years 21 Months 4 Days 13 If less than one day _____ hrs. _____ min.

9. Birthplace Pa.
 (Town, county, and state)

10. Usual occupation Navy

11. Industry or business _____

FATHER 12. Name George Frick
 13. Birthplace Pa.

MOTHER 14. Maiden name Anna E. Endressen
 15. Birthplace Norway

16. Informant Mother: Mrs. Anna E. Frick
 Address 146 Kingdon Avenue, Huguenot Park, L.I.N.Y.

17. removal Date thereof 9-10-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____
 Location Pottstown, Penn.
W. W. Chambers

18. Funeral director P.J.A.
 Address 1400 Chapin St., N. W., Wash., D. C.

19. 10 Sept. 46 Mary Charlotte Smith
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Sept. 19 46 at 2:45A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
15 June 19 46 to 10 Sept. 19 46
 and that I last saw him alive on 10 Sept. 19 46

Immediate cause of death Respiratory failure
 Due to Brain tumor, metastatic; 2 months
 Due to Adrenal tumor; malignant; 2 months
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results Confirmed above.
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE E. N. Weaver
E. N. WEAVER, Lt. (jg) USNR (MC.)
 M. D. or other _____
 Address USNH Bethesda, Md. Date signed 9-10-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9/17/46

RECEIVED

SEP 18 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 530 ✓

CERTIFICATE OF DEATH

09126

Reg. Diat. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 months, 7 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 2 months, 7 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State W. Va. County _____
City or town Martinsburg
(If outside city or town limits, write RURAL and give nearest town)
Street No. RFD #4
(If rural, give LOCATION)
2. (a) If veteran, name war _____ ✓

3. (a) FULL NAME

FULK, Albert Owen,

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife _____

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) November 11, 1901

8. AGE: Years 44 Months 9 Days 28 If less than one day _____ hrs. _____ min.

9. Birthplace W. Va.
(Town, county, and state)

10. Usual occupation veteran

11. Industry or business _____

FATHER 12. Name Charles Fulk

13. Birthplace W. Va.

MOTHER 14. Maiden name Rose Ann Tansel (dec)

15. Birthplace W. Va.

16. Informant father: Mr. Charles R. Fulk

Address RFD #4, Martinsburg, W. Va.

17. removal Date thereof 9-10-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory _____

Location Martinsburg, W. Va.

18. Funeral director Deal Funeral Home

Address 4812 Georgia Avenue, N. W., Wash., D. C.

19. 9-9 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9 Sept. 19 46 at 12:20A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 2 July 19 46 to 9 Sept. 19 46 and that I last saw him alive on 9 Sept. 19 46

Immediate cause of death adenocarcinoma of parotid gland (left) with metastases
Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Biopsy lymph node right chest - adenocarcinoma metastases
Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. N. GRANT, Comdr. (MC) USN
M. D. or other _____

Address USNM Bethesda, Md. Date signed 9-9-46

MARGIN RESERVED FOR BINDING

9VS A15 9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9/14/46

RECEIVED
SEP 17 1946
BUREAU V. E.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
 City or town Ashton
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 60 years
 Hospital, institution, or street address where death occurred:
None
 How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Ashton
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. None
 (If rural, give LOCATION)
 2.(a) If veteran, name war No

3.(a) FULL NAME

Peyton Morgan

3.(b) Social Security Number

None

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Divorced
 6.(b) Name of husband or wife None
 7. Birth date of deceased (mo., day, yr.) July 10, 1877 6.(c) If alive, give age _____ years
 8. AGE: Years 69 Months 2 Days 6 If less than one day _____ hrs. _____ min.
 9. Birthplace Washington, D.C.
 (Town, county, and state)
 10. Usual occupation Retired Icecream Mfg.
 11. Industry or business Mfg. Icecream
 12. Name Mordecai Taylor Fussell
 13. Birthplace Baltimore, Md.
 14. Maiden name Isabelle Velair Fowler
 15. Birthplace Baltimore, Md.

16. Informant Norris Fussell
 Address Ashton, Md.
 17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof Sept. 17, 1946
 (month) (day) (year)
 Cemetery or crematory Greenmount Cemetery
 Location Baltimore, Maryland
 18. Funeral director Wm. Randolph Humphreys
 Address Bethesda, Maryland
 19. 9-17 1946 B. Lawler
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept 16 1946, at 1:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 10, 1946 to Sept. 16, 1946
 and that I last saw him alive on Sept. 16, 1946
 Immediate cause of death Coronary occlusion

DURATION

Due to _____
 Due to _____
 Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work? _____

23. SIGNATURE Frank J. Bronhart M.D. M. D. or other _____
 Address Washington, Md. Date signed 9-16-46

WJ
OCT 18 1946
BUREAU U.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 159

CERTIFICATE OF DEATH

09339223
Reg. Dist. No.

1. PLACE OF DEATH:

County Washington Sanitarium and HospitalCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 14 hours 30 minutes

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 14 hours 30 minutes

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington, D.C. County —City or town Washington
(If outside city or town limits, write RURAL and give nearest town)Street No. 105 D St N.E.
(If rural, give LOCATION)2.(a) If veteran, name war ✓

3. (a) FULL NAME

Baby Boy Harvey

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Single6.(b) Name of husband or wife —7. Birth date of deceased (mo., day, yr.) September 28, 19468. AGE: Years — Months — Days — It less than one day 14 hrs. 30 min.9. Birthplace Takoma Park Montgomery, Maryland
(Town, county, and state)10. Usual occupation —11. Industry or business —12. Name Clarence W. Harvey (Deceased)13. Birthplace 214. Maiden name Cornelia Nocifora15. Birthplace West Virginia16. Informant Records - Washington Sanitarium and HospitalAddress 700 Carroll Avenue Takoma Park, Maryland17. (Burial, cremation, or removal. Which?) — Date thereof (month) (day) (year)Cemetery or crematory Washington Sanitarium + HospitalLocation Takoma Park, Md.19. Funeral director Washington Sanitarium + HospitalAddress Takoma Park, Md.19. Sept 28 1946
(Date rec'd by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1946 at 5:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 28 1946 to Sept 28 1946
and that I last saw him alive on Sept 28 1946

Immediate cause of death

atelectasis

DURATION

Due to Pneumonia BirthDue to —Other conditions —

(Include pregnancy within 3 months of death)

Major findings of operations —Date of op. —Autopsy results —

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide — Date of —

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) —Means of injury —Injured at work? —23. SIGNATURE Robert A. Hare

M. D. or other

Address Takoma Park, Md. Date signed 9/29/46

RECEIVED

OCT 2 1946

BUREAU V.S.

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 742

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 8 years

Hospital, institution, or street address where death occurred:

4501 Windsor Lane,How long in hospital or institution? None

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery

City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 4501 Windsor Lane

(If rural, give LOCATION)

None

2.(a) If veteran, name wnr.....

3. (a) FULL NAME

WILLIAM ALEXANDER HIPKINS JR.

3. (b) Social Security Number

None

4. Sex

Male

5. Color or race

White

6.(a) Single, married, widowed, or divorced

Married

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1946 at 6:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

.....19....., for.....19.....

and that I last saw him.....alive on.....19.....

Immediate cause of death DEP. MED. EXAM. CASE DURATIONCoronary occlusionFound dead in bed

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?..... (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE..... M. D. or other

Address Gaithersburg, Maryland Date signed 9/19/466.(b) Name of husband or wife Agnes Gould Hipkins6.(c) If alive, give age 43 years7. Birth date of deceased (mo., day, yr.) June 27, 1903

8. AGE:	Years	Months	Days	If less than one day
<u>43</u>	<u>43</u>	<u>2</u>	<u>22</u>hrs.min.

9. Birthplace Washington, D.C.
(Town, county, and state)10. Usual occupation Clerk11. Industry or business Washington D.C. Post Office12. Name William A. Hipkins SR.13. Birthplace Alexandria, Virginia14. Maiden name Mary Keogh15. Birthplace Washington, D.C.16. Informant Mrs. Agnes G. Hipkins (wife)Address Bethesda, Maryland.17. Burial Burial Date thereof Sept. 21, 1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Rock Creek CemeteryLocation Washington, D.C.18. Funeral director Wm. Paulsen HumphreyAddress Bethesda, Maryland19. 9/19 46 John E. Lohr

(Date received by registrar) Registrar

RECEIVED

SEP 23 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

09129

Reg. Dist. No. 218

1. PLACE OF DEATH:
 County Montgomery
 City or town Beltsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 12 hr
 Hospital, institution, or street address where death occurred:
State Road Con. Office
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
 (For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town Beltsville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 2005 Hanover St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME
William H. Hobbs Jr

3. (b) Social Security Number
212-16-3105

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Sarah Hobbs
 7. Birth date of deceased (mo., day, yr.) Oct 13 1889 8. (c) If alive, give age 57 years

8. AGE: Years 56 Months 10 Days 23 If less than one day
1889 hrs. min.

9. Birthplace Maryland
 (Town, county, and state)

10. Usual occupation State Rd. Employee

11. Industry or business " "

12. Name William H. Hobbs Jr

13. Birthplace md

14. Maiden name Ida Bazell

15. Birthplace md

16. Informant Wm Sarah Hobbs

Address 2005 Hanover St Beltsville

17. Arranged for Burial Date thereof 9/8/46 (month) (day) (year)

(Burial, cremation, or removal. Which?)

Cemetery or crematory Sykesville Cemetery

Location Sykesville Md

18. Funeral director Wm & Son, Inc

Address Sykesville Md

19. Sept 6 46 (Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 6 1946 at 7:40 A.M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Def med Exam 19 to 19

and that I last saw him alive on 19

Immediate cause of death

Coronary occlusion

Due to sudden

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

Signature Frank J. Bruchart M.D.

23. SIGNATURE Def med Exam M. D. or other

Address Beltsville Md Date signed 9-6-46

RECEIVED
SEP 9 1945
BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (9-5)

CERTIFICATE OF DEATH

Reg. Dist. No. 09130 223-

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 4 1/2 hours
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 4 1/2 hrs.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Silver Spring
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 7917 Takoma Ave.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____

3.(a) FULL NAME

A.
Lessee Hostutler

3.(b) Social Security Number

578-05-7186

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

male white married

6.(b) Name of husband or wife Ruth Hostutler

6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) January 31, 1903

8. AGE: Years 43 Months 7 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Hundred, West Virginia
(Town, county, and state)10. Usual occupation Auditor

11. Industry or business _____

12. Name Spencer Hostutler13. Birthplace Penna14. Maiden name Estelle Kuhn15. Birthplace Penna18. Informant Washington Sanitarium RecordsAddress Takoma Park, Maryland17. Burial Date thereof Sept. 26, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort LincolnLocation Bladensburg Rd. - Ft. Georges Co. Md.19. Funeral director Waxner & HumphreyAddress Silver Spring - Md.19. Sept 24 1946 Registrar J. M. Decker

(Date rec'd by registrar)

MEDICAL CERTIFICATION

2D. DATE OF DEATH Sept. 24 19 46, at 1:40 A.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 23 19 46 to Sept. 24 19 46 and that I last saw him alive on Sept. 23 19 46Immediate cause of death Septic hemorrhage DURATION 6 1/2 hrs.Due to Possible embolism or infarction of stomach 2 daysDue to Bacterial endocarditis 2-3 mo.
(Subacute - healed)

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE J. M. Decker M. D. or other _____Address Silver Spring, Md. Date signed 9/24/46

RECEIVED
SEP 26 1946
BUREAU

Evidence for the addition of
usual residence is shown
on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

FILM No. I 07 OCT 22 1946

CERTIFICATE OF DEATH

Reg. Dist. No.

09131
216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 11 1/3 Days
Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
How long in hospital or institution? 11 1/3 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Washington D. C. County Washington D. C.
City or town Washington D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1130 6th St. N. W. & Mr. L. D. McDuffey
(If rural, give LOCATION)
2. (a) If veteran, name war World War I

3. (a) FULL NAME

Mike (n) HOWARD

3. (b) Social Security Number

4. Sex male 5. Color or race Negro 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) 25 August 1895

8. AGE: Years 51 Months 0 Day 12 If less than one day hre. min.

9. Birthplace North Carolina
(Town, county, and state)
veteran

10. Usual occupation

11. Industry or business

12. Name Bratt Howard

13. Birthplace N.C.

14. Maiden name Anna Wall

15. Birthplace N.C.

16. Informant L. D. McDuffey

Address 1130 6th St. N.W. Wash., D.C.

17. burial Date thereof 9-13-46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Arlington National

Location Arlington, Va.

18. Funeral director Ernest W. Jarvis

Address 1432 U St., N. W., Wash., D.C.

19. 9 Sept 46
(Date rec'd by registrar) Registrar Mary Charlotte Smith

MEDICAL CERTIFICATION

20. DATE OF DEATH 6 September 19 46 10:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 16 April 19 46 to 6 Sept. 19 46
and that I last saw him alive on 6 Sept. 19 46

Immediate cause of death Carcinoma Bronchogenic DURATION 7

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Frank S. Ashburn, Lt. Cdr. (MC) USN
M. D. or other

Address Nav Hosp Bethesda, Md. Date signed 9-9-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

9/14/46

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED
SEP 17 1946
BUREAU V. M.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 160-2

CERTIFICATE OF DEATH

0913223

Reg. Dist. No.

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 45 minHospital, institution or street address where death occurred:
Washington Sanitarium + Hosp.How long in hospital or institution? 45 min.

3. (a) FULL NAME

Infant named Cheryl Ann
Baby Huppmann

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white Baby

6. (b) Name of husband or wife Mrs. Agnes Huppmann

6. (c) If alive, give age years

7. Birth date of deceased (mo., day, yr.) 9-22-468. AGE: Years Months Days If less than one day
hrs. 45 min.9. Birthplace Washington San. Hosp.
(Town, county, and state)

10. Usual occupation

11. Industry or business

12. Name Mr. Joseph Huppmann13. Birthplace Washington D.C.14. Maiden name Agnes Harriet Herbert15. Birthplace District of Columbia16. Informant Washington Sanitarium + Hosp.Address Takoma Park, Md.17. Removal Date thereof Sept 23-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Geo. Wash. Mem. Cem.Location Riggs Rd. Md.18. Funeral director Arthur WaltersAddress 254 Carroll St. Takoma Park, Md.19. Sept 23 1946
(Date rec'd by registrar)

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State District of Col. CountyCity or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)Street No. 429 Balafield Place N.W. D.C.

(If rural give LOCATION)

2. (d) If veteran, name war

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-22-1946 at 7 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 6:00 pm 9-22-1946 to 7:00 pm 9-22-1946 and that I last saw her alive on 9-22-1946

Immediate cause of death

Asphyxia pallida -
new born baby, at term
Due to cord around neck &
shoulders. very tight

DURATION

Other conditions Premature separation
placenta - only partial
(Include pregnancy within months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Emma Hughes M.D.
M. D. or otherAddress Takoma Park, Md. Date signed 9-22-46

RECEIVED
SEP 24 1940
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 949

CERTIFICATE OF DEATH

09133

Reg. Dist. No. 244

1. PLACE OF DEATH:

County... Montgomery
 City or town... Beltsville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? few days
 Hospital, institution, or street address where death occurred:
R.F.D.
 How long in hospital or institution? —

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... D.C. County...
 City or town... Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1342 Morris Rd S.E.
 (If rural, give LOCATION)
 2(a) If veteran, name war... ✓

3. (a) FULL NAME

Charles Jenkins

3. (b) Social Security Number

579-20-2135

4. Sex Male 5. Color or race col 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Anna Jenkins
 7. Birth date of deceased (mo., day, yr.) Feb 16 1889 6. (c) If alive, give age 46 years
 8. AGE: Years 29 1/2 Months 6 Days 28 If less than one day
hrs. min.

9. Birthplace S.C.
 (Town, county, and state)

10. Usual occupation laborer

11. Industry or business

12. Name unknown
 13. Birthplace

14. Maiden name unknown
 15. Birthplace

16. Informant Anna Jenkins
 Address 1342 Morris Rd S.E. Wash DC

17. Buried Date thereof Sept 16 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Woodlawn
 Location Washington D.C.

18. Funeral director R. L. Snowden
 Address Rockville, Md.

19. Sept 16 19 46 Josephine Schaeffer
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 19 46 at 12:30 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept med. Exam case 19 46

and that I last saw him alive on Sept 14 19 46

Immediate cause of death Coronary occlusion

Due to Coronary occlusion

Due to Coronary occlusion

Other conditions Coronary occlusion

(Include pregnancy within 8 months of death)

Major findings of operations Coronary occlusion

Date of op. Sept 14 1946

Autopsy results Sept med. Exam

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Sept med. Exam Date of Sept 14 1946

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury Sept med. Exam Injured at work?

23. SIGNATURE Frank J. Brochant M.D.

Address Washington Md Date signed 9-14-46

REC'D
SEP 17 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 85-29

CERTIFICATE OF DEATH

Reg. Dist. No. 09134 217

1. PLACE OF DEATH:

County Montgomery
 City or town Olney, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital

How long in hospital or institution?

9 days.

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Olney
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____
 (If rural, give LOCATION)

2.(a) If veteran, name war _____

3. (a) FULL NAME

Mr. Josiah W. Jones

3. (b) Social Security Number

213-14-2691

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Male White Married

6. (b) Name of husband or wife. Margaret Elgar Sherman Jones

6. (c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) March 3, 1870

8. AGE: Years Months Days If less than one day
76 6 3 _____ hrs. _____ min.

9. Birthplace Olney, Montgomery County, Md.
(Town, county, and state)10. Usual occupation Farmer and Barker

11. Industry or business _____

12. Name Mr. Josiah W. Jones13. Birthplace Prince George Co., Md.14. Maiden name Mary Elizabeth Barnsley15. Birthplace Olney, Md.16. Informant Hospital records

Address

17. Burial Date thereof Sept 9 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Friends CemeteryLocation Sandy Springs Md.18. Funeral director Wm. E. HumphreyAddress Sandy Springs, Md.19. Sept 6 1946 Seaton Lawler

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 6 1946, at 12:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
August 28 1946 to Sept 6 1946
 and that I last saw him alive on Sept 6 1946

Immediate cause of death Cerebral Hemorrhage DURATION 10 min
60 yrs

Due to asthma

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Chas B. Tumbleson M. D. ocathor

Address Sandy Springs, Md. Date signed 9/6/46

RECEIVED
SEP 12 1946
BUREAU V &

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 467

09135

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH: County <u>Montgomery</u> City or town <u>Bethesda</u> (If outside city or town limits, write RURAL and give nearest town) How long in above place of death? Hospital, institution, or street address where death occurred: <u>Suburban Hospital</u> How long in hospital or institution?				2. USUAL RESIDENCE (HOME) OF DECEASED: (For newborn infants give residence of mother) State <u>D.C.</u> County City or town <u>Washington</u> (If outside city or town limits, write RURAL and give nearest town) Street No. <u>4123 Harrison St., N.W.</u> (If rural, give LOCATION) 2.(a) If veteran, name war.			
3. (a) FULL NAME <u>INEZ DeMONTREVILLE KECK</u>				3. (b) Social Security Number			
4. Sex <u>Female</u>		5. Color or race <u>White</u>		6. (a) Single, married, widowed, or divorced <u>Married</u>		MEDICAL CERTIFICATION	
6. (b) Name of husband or wife <u>William W. Keck</u>		B. (c) If alive, give age years		20. DATE OF DEATH <u>11 September 1946</u> , at <u>6:30 A.M.</u>		21. I CERTIFY that death occurred on the date above stated; that I attended deceased from <u>4 April 1946</u> to <u>11 Sept. 1946</u> and that I last saw her alive on <u>10 Sept. 1946</u>	
7. Birth date of deceased (mo., day, yr.) <u>Oct. 3rd., 1876</u>		8. AGE: Years <u>69</u> Months Days If less than one day hrs. min.		Immediate cause of death <u>Hemorrhage from stomach</u>		DURATION <u>6 days</u>	
9. Birthplace <u>Minn.</u> (Town, county, and state)		10. Usual occupation <u>Housewife</u>		Due to <u>Carcinoma in wall of stomach</u>		6 months plus	
11. Industry or business		12. Name <u>Clarence DeMontreville</u>		Other conditions <u>Intestinal obstruction, partial of small intestine, Cholelithiasis</u>		10 days 5 yrs plus	
13. Birthplace <u>Jamica, N.Y.</u>		14. Maiden name <u>Mary Moore</u>		Major findings of operations <u>None</u>		Date of op.	
15. Birthplace <u>Ireland</u>		16. Informant <u>Mrs. Dorothy Green</u> Address <u>5410-13th., St., N.W.</u>		Autopsy results <u>As above plus old coronary occlusion</u>		PHYSICIAN: Please underline the cause to which death should be charged statistically.	
17. Removal <u>9/11/46</u> (Burial, cremation, or removal. Which?) Date thereof..... (month) (day) (year)		Cemetery or crematory <u>Washington, D.C.</u> Location		22. VIOLENCE: If death was due to external causes, fill in the following: Accident, suicide, or homicide..... Date of..... Where did injury occur?..... (City or town) (County) (State) Injured at home, farm, industry, public place (where?)..... Means of injury..... Injured at work?.....		23. SIGNATURE <u>Stewart Bluff M.D.</u> Address <u>3921 Ingomar St. N.W. D.C.</u> Date signed <u>9-12-46</u>	
18. Funeral director <u>Cherry Chase Funeral Home</u> Address <u>5103 Wis. Ave., N.W.</u>		19. Date rec'd by registrar <u>9/12/46</u> <u>Wm E Jones</u> Registrar					

RECEIVED
SEP 14 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 469

CERTIFICATE OF DEATH

Reg. Dist. No. 216

09136

1. PLACE OF DEATH

County MontgomeryCity or town Bethesda, Md.
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

SuburbanHow long in hospital or institution? 5 days 23 hrs 31 min

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 4203 Leland

(If rural, give LOCATION)

(a) If veteran, name war No

3. (a) FULL NAME

Mary Elizabeth Kennedy

3. (b) Social Security Number

None

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband or wife

E. Russell

7. Birth date of

deceased (mo., day, yr.)

Oct 4 1878

6. (c) If alive, give age..... years

8. AGE:

Years

Months

Days

If less than one day

671116

hrs.

min.

9. Birthplace

Baltimore Md.
(Town, county, and state)

10. Usual occupation

Housewife

11. Industry or business

FATHER

12. Name

William C. Short

13. Birthplace

Virginia

MOTHER

14. Maiden name

Mary Mitchell

15. Birthplace

Virginia

16. Informant

E. Russell Kennedy

Address

4203 Leland St. Ch. Ch. Md.17. Burial

(Burial, cremation, or removal. Which?)

Date thereof

9/23/46

Cemetery or crematory

Natl. Memorial Park Cem.

Location

Virginia

18. Funeral director

Wm Reuben Humphrey

Address

Bethesda, Md.

19.

9/21

19.

46Wm E. Jones

(Date rec'd by registrar)

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 20 19 46, at 11:00 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

June 19 44, to Sept 19 46and that I last saw him alive on Sept 19 19 46

Immediate cause of death

Cancer of Pancreas

DURATION

2 yrs

Due to

Primary carcinoma of pancreas

Due to

Cancer

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Same as Acute Peritonitis

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, till in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Wm E. Jones

M. D. or other

Address 4203 Leland St. Ch. Ch. Md. Date signed 9/20/46

RECEIVED
SEP 24 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 161-0

CERTIFICATE OF DEATH

09137223
Reg. Diat. No.

1. PLACE OF DEATH:

County Montgomery
City or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 2 days
Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 9501 Bruce Drive
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME

Kennedy, Unnamed Baby Boy Wayne Allard

3. (b) Social Security Number

4. Sex Male 5. Color or race white 6.(a) Single, married, widowed, or divorced —
6.(b) Name of husband or wife —
6.(c) If alive, give age — years
7. Birth date of deceased (mo., day, yr.) September 20, 1946
8. AGE: Years 2 Months 9 1/2 Days 9 1/2 hrs. — min.
8. Birthplace Takoma Park Md. Montg.
(Town, county, and state)

10. Usual occupation —
11. Industry or business —
12. Name George Bowman Kennedy
13. Birthplace Lebanon, Pa.
14. Maiden name Thelma Allard
15. Birthplace Takoma Park, Md.
16. Informant Mother's record - Wash. San. & Hosp.
Address Takoma Park, Md.
17. Burial Date thereof Sept. 24-1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Prospect Hill Cemetery
Location Washington, D.C.
18. Funeral director J. Arthur Walters
Address 254 Emma St. Takoma Park
19. Sept 24 46 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 23, 1946 at 9⁰⁰ a.m.
21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9-20-1946 to 9-23-1946 and that I last saw him alive on 9-23-1946
Immediate cause of death Bilateral necrosis adrenals with hemorrhage in new form.
DURATION
Due to
Due to
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations
Date of op.

Autopsy results
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide
Where did injury occur? (City or town) (County) (State)
Injured at home, farm, industry, public place (where?)
Means of injury Injured at work?

23. SIGNATURE John H. McLeod M. D. or other
Address 1801 Eye St. NW Date signed 9/27/46

RECEIVED

SEP 25 1945

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 186-a

CERTIFICATE OF DEATH

Reg. Dist. No.

09138 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 4 days

Hospital, institution, or street address where death occurred:

Washington Sanitarium and HospitalHow long in hospital or institution? 4 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. Arcola Avenue, Route #1
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Albert Bernard King

3. (b) Social Security Number

214-03-8199

4. Sex

male

5. Color or race

Cauc.

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age. years

7. Birth date of deceased (mo., day, yr.) January 4, 1908

8. AGE: Years Months Days If less than one day

38819

hrs. min.

9. Birthplace Howard County, Maryland
(Town, county, and state)10. Usual occupation laborer11. Industry or business Construction12. Name Harry Joseph King13. Birthplace Ellicott City, Maryland14. Maiden name Aliae Dennis15. Birthplace Clarksville, Maryland16. Informant Washington Sanitarium & Hospital RecordsAddress Takoma Park, Maryland17. BURIAL Date thereof SEP-25-1946

(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory FORT LINCOLNLocation BLADENSBURG RD. PRINCE GEORGES CO18. Funeral director Werner E. PumphreyAddress SILVER SPRING MD19. Sept 24 46

(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 23 1946, at 4:10 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 19, 1946 to Sept 23, 1946and that I last saw him alive on Sept 19, 1946Immediate cause of death Fracture of 5th& 6th cervical vertebraewith trauma of cordDue to fall - (accidental)

Due to

Other conditions epilepsy

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide accidental Date of 9-19-46Where did injury occur? Silver Spring R-1 Md.

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) homeMeans of injury fall from home Injured at work? yes23. SIGNATURE Frank J. Broschart M.D.Address Washington Md Date signed 9-23-46

M. D. or other

RECEIVED

SEP 26 1945

BUREAU

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93d

CERTIFICATE OF DEATH

09139

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Chevy Chase, Md.
(If outside city or town limits, write RURAL NEAR and give town)
Street address, hospital, or institution:
1817 Drummond Avenue
Stay in hospital or inst. (yrs., or mos., or days) _____
Stay in this community (yrs., or mos., or days) _____

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Md County _____
City or town Chevy Chase Ward No. _____
(If outside city or town limits, write RURAL NEAR and give town)
Street No. 4817-Drummond Ave
(If rural give LOCATION)
2(a) IF VETERAN, NAME WAR _____

3. (a) FULL NAME

Carrie B. Matthews

3. (b) Social Security Number

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widowed

6. (b) Name of husband or wife Jerome P.

6(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) October 10, 1872

8. AGE: Years 73 Months _____ Days _____ If less than one day _____ hrs. _____ min.

9. Birthplace Crisfield, Maryland
(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business _____

FATHER 12. Name Cornelius Sterling

13. Birthplace Maryland

MOTHER 14. Maiden name Pollie --

15. Birthplace Maryland

16. Informant Kenneth F. Matthews

Address _____

17. Burial Date thereof Sept. 11, 1946
(Burial, cremation, or removal, which?) (month) (day) (year)

Cemetery or crematory Ft. Lincoln Cems.

Location _____

18. Funeral director The S. H. Finies Co

Address 2901-14 - at N. W. Washington D. C.

19. 9/9 19 46 Thm E Jones
(Date rec'd by registrar) Registrar E

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/9/46 19 46 at 9:30 M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 8/6/46 19 46 to 9/9/46 19 46 and that I last saw him alive on 9/8/46 19 46

Immediate cause of death Hypostatic pneumonia
complicated by
Myocarditis.
Due to Hypertension.
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings:

Of operations _____

Of autopsy _____

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE R. N. Mangano M.D.

Address 1410 - Main St. NW Date signed 9/9/46

DURATION

1 week
27 yrs
45 yrs

PHYSICIAN

Please underline the cause to which death should be charged statistically.

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Every item of information should carefully be supplied. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 10 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

RECEIVED
SEP 17 1946
BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (46-2) ✓

CERTIFICATE OF DEATH

09141

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Near Glenmont, Maryland
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 3 days

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Prince GeorgeCity or town Landover
(If outside city or town limits, write RURAL and give nearest town)Street No. _____
(If rural, give LOCATION) ✓

2.(a) If veteran, name war _____

3. (a) FULL NAME

Elizabeth Ottens

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Married6. (b) Name of husband or wife Herman C. Ottens6. (c) If alive, give age 65 years

7. Birth date of deceased (mo., day, yr.)

March 28, 1884

8. AGE:

62

Years

Months

5

Days

22

If less than one day

.....hrs.min.

9. Birthplace Reading, England

(Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

FATHER
MOTHER

12. Name

Johnson

13. Birthplace

Reading, England

14. Maiden name

Nellie Townsend

15. Birthplace

Reading, England16. Informant Herman C. OttenAddress Landover, Maryland17. Burial
(Burial, cremation, or removal. Which?)Date thereof Sept. 23, 1946
(month) (day) (year)

Cemetery or crematory

Prospect Hill

Location

Washington, D.C.

18. Funeral director

Warner E. Pumphrey

Address

Silver Spring, Md.

19.

(Date rec'd by registrar)

Sept 211946Josephine Schaffer
Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH September 19 19 46 at 11:45 A.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 17 19 46 to Sept. 19 19 46and that I last saw her alive on September 19 19 46Immediate cause of death Carcinoma of intestines.

DURATION

With metastases.Unknown

Due to _____

Due to _____

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____

No

Date of op. _____

Autopsy results No

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide No Date of _____Where did injury occur? _____
(City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____

Injured at work? _____

23. SIGNATURE

Chas. E. Pumphrey

M. D. Certificate

Address Sandy Spring, Maryland Date signed 9-19-46

RECEIVED
SEP 24 1948
BUREAU V. H.

RECEIVED
SEP 26 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 131-a

CERTIFICATE OF DEATH

09143

Reg. Dist. No. 21.3

1. PLACE OF DEATH:

County Montgomery
 City or town rural - Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 32 years
 Hospital, institution, or street address where death occurred:
Avery
 How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State Maryland County Montgomery
 City or town rural - Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. Avery
 (If rural, give LOCATION)
 2.(a) If veteran, name war

3. (a) FULL NAME

Sarah Ethel Penn

3. (b) Social Security Number

4. Sex female 5. Color or race white 6.(a) Single, married, widowed, or divorced married
 6.(b) Name of husband or wife Melvin Penn
 7. Birth date of deceased (mo., day, yr.) October 27, 1878 6.(c) If alive, give age 55 years
 8. AGE: Years 67 Months 11 Days 2 If less than one day
 hrs. min.

9. Birthplace Rockville, Maryland
 (Town, county, and state)

10. Usual occupation Housewife

11. Industry or business

12. Name Elias Price

13. Birthplace Barnesville, Maryland

14. Maiden name Mary Frances Carlisle

15. Birthplace Dickerson, Maryland

16. Informant Mr. Melvin Penn

Address R # 3, Rockville, Maryland

17. Burial Date thereof 10/2/46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Monocacy Cemetery

Location Beallsville, Md.

18. Funeral director W. Robin Humphrey

Address Rockville, Md.

19. 10-2 46 Betty Jane Snyder
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 29, 1946, at 8 P. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

January 12, 1940, to September 29, 1946

and that I last saw him alive on September 29, 1946

Immediate cause of death Heart block

DURATION 2 weeks

Due to Cardio-vascular -

renal disease

Due to 20 years

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Katharine A. Chapman, M.D.

29 West Baltimore St. M. D. or other

Spessington, Md. Address Date signed 9/30/46

RECEIVED
OCT 3 1946
BUREAU V B

N. B.—WRITE PLAINLY, WITH UNFADING INK—THIS IS A PERMANENT RECORD. Every item of information should be carefully supplied. AGE should be stated EXACTLY. PHYSICIANS should state CAUSE OF DEATH in plain terms, so that it may be properly classified. Exact statement of OCCUPATION is very important. See instructions on back of certificate.

STATE OF MARYLAND—CERTIFICATE OF DEATH

09144

1. PLACE OF DEATH

County MontgomeryRegistration Dist. No. 213Village or City RockvilleNo. Chestnut Lodge Sanitarium St. Ward

(If death occurred in a hospital or institution, give its NAME instead of street and number)

Length of residence in city or town where death occurred 11 yrs. 11 mos. 0 ds. How long in U. S. if of foreign birth? 0 yrs. 0 mos. 0 ds.2. FULL NAME Pifer, Ida Little (Mrs.)

If U. S. Veteran, specify WAR

(a) Residence: No. 500 West Montgomery Ave. St. Rockville, Md.

(Usual place of abode)

If nonresident give city or town and State

PERSONAL AND STATISTICAL PARTICULARS

3. SEX <u>Female</u>	4. COLOR OR RACE <u>White</u>	5. SINGLE, MARRIED, WIDOWED, OR DIVORCED (write the word) <u>Divorced</u>
5e. If married, widowed, or divorced HUSBAND of (or) WIFE of <u>Dr. John Pifer</u>		
6. DATE OF BIRTH (month, day, and year) <u>November 22, 1862</u>		
7. AGE <u>83</u> Years	<u>10</u> Months	Days <u>0</u> If LESS than 1 day, <u>0</u> hrs. <u>0</u> min.
OCCUPATION	8. Trade, profession, or particular kind of work done, as SPINNER, SAWYER, BOOKKEEPER, etc. <u>Secretarial work</u>	
	9. Industry or business in which work was done, as SILK MILL, SAW MILL, BANK, etc.	
10. Date deceased last worked at this occupation (month and year)		11. Total time (years) spent in this occupation <u>50</u> yrs.

12. BIRTHPLACE (city or town) Jasper County, Iowa
(State or country)13. NAME William T. Little14. BIRTHPLACE (city or town) Philadelphia
(State or country) Pennsylvania15. MAIDEN NAME Emily Gray16. BIRTHPLACE (city or town) North Carolina
(State or country)17. INFORMANT Patient
(Address)18. BURIAL, CREMATION, OR REMOVAL Interment
Place Greenwood Cem. Rockville, Md. Date Sept. 16, 194619. UNDERTAKER Hines
(Address) 2901 14th St. N. W. D.C.20. FILED 9/25/46 Betty Jane Snyder
Registrar.

MEDICAL CERTIFICATE OF DEATH

21. DATE OF DEATH

September 14, 1946
(Month) (Day) (Year)22. I HEREBY CERTIFY, That I attended deceased from October 16, 1945, to September 14, 1946.I last saw her alive on September 13, 1946; death is said to have occurred on the date stated above, at 8 a.m.

The PRINCIPAL CAUSE OF DEATH and related causes of importance were as follows:

Coronary ThrombosisDate of onset
9/14/46

Other Contributory Causes of Importance:

Generalized arteriosclerosisSenility

Name of operation _____ Date of _____

What test confirmed diagnosis? _____ Was there an autopsy? No

23. If death was due to external causes (VIOLENCE) fill in also the following:

Accident, suicide, or homicide? _____ Date of injury _____, 19____

Where did injury occur? _____

(Specify city or town, county and State)

Specify whether injury occurred in INDUSTRY, in HOME, or in PUBLIC PLACE.

Manner of injury _____

Nature of injury _____

24. Was disease or injury in any way related to occupation of deceased? No

If so, specify _____

(Signed) Alfred H. Hutton M. D.(Address) 500 West Montgomery Ave.

UNITED STATES STANDARD CERTIFICATE OF DEATH

Statement of occupation.—Precise statement of occupation is very important, so that the relative healthfulness of various pursuits can be known. Make some entry in this section for every person aged 10 years or over. If the deceased had retired from business, report the occupation prior to retirement. Children not gainfully employed may be returned as at school or at home. For a woman whose only occupation was that of home housework, write housewife in answer to Question 8 and own home in answer to Question 9. For a person engaged in domestic service for wages, however, designate the occupation by the appropriate terms, as servant—private family, cook—hotel, etc. For a person who had no occupation whatever write none.

To be complete, an occupation return must state:

- 8.—The trade, profession, or particular kind of work done.
- 9.—The industry or business in which the work was done.
- 10.—The month and year the deceased last worked at the occupation.
- 11.—The number of years the deceased followed the occupation.

In stating the occupation, avoid the use of such indefinite terms as "employee," "worker," "operative," etc. Find out the particular kind of work done and return that, as spinner, weaver, etc.

In stating the industry or business, avoid the use of such general terms as "store," "factory," "mill," etc. State the particular kind of store, factory, mill, etc., as grocery store, soap factory, cotton mill, etc.

Distinguish carefully the different kinds of engineers by stating the full descriptive titles, as civil engineer, mechanical engineer, mining engineer, stationary engineer, etc. Avoid the term "laborer" when a more precise statement of the occupation can be secured. Do not use the word "mechanic," but give the exact occupation, as carpenter, painter, machinist, etc. Distinguish carefully between retail merchants and wholesale merchants. A person who sells goods should be called a salesman and not a clerk.

Statement of cause of death.—Cause of death means the disease, injury, or complication which causes death, not the mode of dying, e. g., heart failure, asphyxia, asthenia, etc. As principal cause name the disease or injury causing death. As related causes, name earlier morbid conditions, if any, related to the principal cause and any important complication of the principal cause. Under other contributory causes of importance, name other important diseases or injuries. Examples:

Example I

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Arteriosclerosis</i>	<i>1915</i>
<i>Chronic interstitial nephritis</i>	<i>1921</i>
<i>Cerebral hemorrhage</i>	<i>July 5, 1927</i>
Other contributory causes of importance:	
<i>Gallstones</i>	<i>May 1, 1923</i>

Example II

The principal cause of death and related causes of importance were as follows:	Date of onset
<i>Attack of epilepsy</i>	<i>1 week ago</i>
<i>Run over by street car</i>	<i>1 week ago</i>
<i>Peritonitis</i>	<i>3 days ago</i>
Other contributory causes of importance:	
<i>Gastroenteritis</i>	<i>1 year</i>

ADDITIONAL SPACE FOR FURTHER STATEMENTS BY PHYSICIAN

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore MD

CERTIFICATE OF DEATH

09145

Reg. Dist. No. 218

1. PLACE OF DEATH: Montg Co,
County.....
City or town..... Germantown, Rural
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 38 yrs
Hospital, institution, or street address where death occurred:
.....
How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State..... Md County..... Montg
City or town..... Germantown Rural
(If outside city or town limits, write RURAL and give nearest town)
Street No..... 1
(If rural, give LOCATION)
2.(a) If veteran, name war.....

3. (a) FULL NAME

Lottie Plummer

3. (b) Social Security Number

4. Sex Female 5. Color or race Colored 6.(a) Single, married, widowed, or divorced Married

6.(b) Name of husband or wife Harry Plummer
6.(c) If alive, give age 60 yrs

7. Birth date of deceased (mo., day, yr.) Unknown

8. AGE: Years 56 Months Days If less than one day
About 56 hrs. min.

9. Birthplace Gaithersburg, Md.
(Town, county, and state)
House Keeper

10. Usual occupation.....

11. Industry or business II II

12. Name William Smith

13. Birthplace Md

14. Maiden name Susan Thompson

15. Birthplace Md

16. Informant Cecil Dorsey
Address Germantown Md,

17. Burial Date thereof 9/16/46
(Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Emory Grove Cemetery
Near Gaithersburg, R F D, Md.
Location Ernest C Gartner

18. Funeral director Ernest C Gartner
Address Gaithersburg Md,

19. Sept 16 1946 Abner L. Cooke
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 14 1946 at 11 A.M.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from Sept - 12 - 1946 to Sept - 14 - 1946
and that I last saw him alive on Sept - 14 - 1946

Immediate cause of death acute heart failure
DURATION 5-10 minutes

Due to acute pulmonary
4 days

Due to 1946 - pulmonary - probably from frog

Other conditions.....

(Include pregnancy within 8 months of death)

Major findings of operations.....

.....Date of op.....

Autopsy results.....
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE William C. Miller, M.D.
M. D. or other
Address Gaithersburg, Md. Date signed 9/19/46

RECEIVED
SEP 18 1946
BUREAU V C

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 137-2

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda, Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? Since Aug.
 Hospital, institution, or street address, where death occurred:
Suburban Hosp
 How long in hospital or institution?.....

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State... Maryland County... Montgomery
 City or town... Rockville
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. R.R. #2 - Montrose Rd.
 (If rural, give LOCATION)
 2.(a) If veteran, name war.....

3. (a) FULL NAME

Mr Wickcliff Pollen

3. (b) Social Security Number

4. Sex M 5. Color or race W 6.(a) Single, married, widowed, or divorced married

6.(b) Name of husband or wife... Anne Pollen - Dec.

7. Birth date of deceased (mo., day, yr.) April 8, 1866 6.(c) If alive, give age..... years

8. AGE: Years 80 Months 4 Days 26 If less than one day..... hrs. min.

9. Birthplace... Prince Wm Co Virginia
 (Town, county, and state)

10. Usual occupation... ?

11. Industry or business

12. Name... Geo. Pollen

13. Birthplace... Prince Wm Co Virginia

14. Maiden name... Mary Forsythe

15. Birthplace... ? Virginia

16. Informant... Eleanor Pollen

Address... Rockville - Md

17. Burial Date thereof... Sept 6 / 46
 (Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory... Glenwood Cem

Location... Shack, DC

18. Funeral director... J. J. Chambers Co

Address... 3072 - N 5th W. Wash, D.C.

19. 9 / 3 19 46 Wm E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 3 Sept 19 46 at 5:17 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 27 August 19 46 to 3 Sept 19 46

and that I last saw him alive on 0500 3 Sept 19 46

Immediate cause of death... Terminal pneumonia

Prostatic hypertrophy with

urinary retention

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur?.....
 (City or town) (County) (State)

Injured at home, farm, industry, public place (where?).....

Means of injury..... Injured at work?

23. SIGNATURE... A. G. Levensohn MD M. D. or other

Address... Suburban Hospital Date signed 3 Sept 46
Rockville - Md.

RECEIVED

SEP 4 1946

BUREAU

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

1645

CERTIFICATE OF DEATH

Reg. Dist. No.

00147213

1. PLACE OF DEATH:

County MontgomeryCity or town Derwood
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 60 yrs.Hospital, institution, or street address where death occurred:
Redland, Derwood, Md.How long in hospital or institution? no

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Derwood, R.F.D.
(If outside city or town limits, write RURAL and give nearest town)Street No. Redland
(If rural, give LOCATION)2.(a) If veteran, name war no

3. (a) FULL NAME

Carson W. Pope

3. (b) Social Security Number

NONE

4. Sex male 5. Color or race white 6.(a) Single, married, widowed, or divorced married6.(b) Name of husband or wife Mrs. Amy B. Pope6.(c) If alive, give age ? years7. Birth date of deceased (mo., day, yr.) May 19, 18778. AGE: Years 69 Months 3 Days 19 If less than one day hrs. min.9. Birthplace Ft. Seybert, W. Va.
(Town, county, and state)10. Usual occupation Farmer11. Industry or business Farming12. Name Henry W. Pope13. Birthplace West Va.14. Maiden name Anne Brake15. Birthplace West Va.16. Informant Mrs. Amy B. PopeAddress Redland, Derwood, Md.17. Burial Rockville Union Cemetery Date thereof Sept. 25, 1946
(Burial, cremation, or other disposition) (month) (day) (year)Cemetery or crematory Rockville Union CemeteryLocation Rockville, Md.18. Funeral director Wm. Reuben PumphreyAddress 7557 Wis. Ave., Bethesda, 14, Md.19. 9-25 46 Betty Jane Snyder
(Data rec'd by registrar) (Date) (Time) (Signature)

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 23 1946 at 10:00 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 19 to Sept. 23and that I last saw him alive on Sept. 23Immediate cause of death Heartdue to gun shot woundin left chest overdue to heart(suicide)Due to (suicide)Other conditions (suicide)

(Include pregnancy within 3 months of death)

Major findings of operations (suicide)Date of op. (suicide)Autopsy results (suicide)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide suicide Date of 9-23-46Where did injury occur? Washington R. 2 mi. N. of (City or town) (County) (State)Injured at home, farm, industry, public place (where?) farmMeans of injury shot gun Injured at work? noSignature Frank J. Brochart M.D.Address Washington R. 2 mi. N. of Date signed 9-23-4623. SIGNATURE Frank J. Brochart M.D.Address Washington R. 2 mi. N. of Date signed 9-23-46

RECEIVED
SEP 26 1944
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 446

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 10 years
 Hospital, institution, or street address where death occurred:
6100 Brookville Rd.
 How long in hospital or institution? none

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Chevy Chase
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 6100 Brookville Rd.
 (If rural, give LOCATION)
 2. (a) If veteran, name war none

3. (a) FULL NAME

MRS. ZELLA CLIFORD PORTER

3. (b) Social Security Number

none

4. Sex female 5. Color or race white 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Andrew D. Porter6. (c) If alive, give age deceased7. Birth date of deceased (mo., day, yr.) February 29, 1884

8. AGE: Years 62 Months 7 Days 1 If less than one day
hrs.min.

9. Birthplace Canada
(Town, county, and state)10. Usual occupation housewife11. Industry or business home12. Name Oscar F. Clifford13. Birthplace Illinois14. Maiden name Alice Nigh15. Birthplace Ohio16. Informant Mrs. Audrey P. BaldersonAddress Chevy Chase, Md.17. Burial Date thereof Sept. 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Rock Creek CemeteryLocation Washington, D. C.18. Funeral director Wm. E. JonesAddress Bethesda, Maryland19. 9/5 46 Wm. E. Jones
(Date rec'd by registrar) (year) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1946 at 10:02 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 9, 1943 to 9-3, 1946
 and that I last saw him alive on Sept. 2, 1946

Immediate cause of death Nodular Disease with extensive metastases to skeletal system and lungs.

DURATION

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results.....

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, term, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Edgar M. McPeak M. D. or otherAddress 1835-Eye NW. Date signed 9/5/46

RECEIVED

SEP 7 1945

BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1246

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Md.
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 14 days
 Hospital, institution, or street address where death occurred:

Suburban Hospital

How long in hospital or institution? 14 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County

City or town Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

Street No. R.R. #3
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Oliver T. Redden

3. (b) Social Security Number

4. Sex m 5. Color or race W 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Mary Jane Redden

7. Birth date of deceased (mo., day, yr.) Oct. 14 1877

8. AGE: Years 68 Months 10 Days 14 If less than one day hrs. min.

9. Birthplace Crofton, Montgomery Co., Md.
 (Town, county, and state)

10. Usual occupation ? Farmer Carpenter

11. Industry or business

12. Name Wm. T. Redden

13. Birthplace Maryland

14. Maiden name Isabel Pennifill

15. Birthplace Maryland

16. Informant Mr. Wm. T. Redden

Address 809 - 18th St. N.W.

17. Burial (Burial, cremation, or removal. Which?) Burial Date thereof 9/5/46
 (month) (day) (year)

Cemetery or crematory Norman Church Cem.

Location in River Rd Bethesda, Md.

18. Funeral director Wm. Reuben Humphrey

Address 7557 Wis. Ave. Bethesda, Md.

19. 9/3 46 Wm E Jones
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9-2 19 46 at 3:25 P.M.

21. I CERTIFY that death occurred on the date above stated; That I attended deceased from 19 August 19 46 to 2 Sept 19 46

and that I last saw him alive on 320 p.m. Sept 2 19 46

Immediate cause of death Arteriosclerotic heart disease DURATION years

Arteritis, pneumonia & embolism weeks

Due to upper intracranial hemorrhage

Due to embolism of the liver years

Other conditions malnutrition years

Arteriosclerotic degeneration

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE A. N. Levensohn, M.D. M. D. or other

Address Suburban Hospital Date signed 3 Sept 1946

Bethesda, Md.

RECEIVED

SEP 5 1946

BUREAU V. S.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1172

CERTIFICATE OF DEATH



09150

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

902 Gist Ave.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 902 Gist Ave.
(If rural, give LOCATION)2.(a) If veteran, name war X

3. (a) FULL NAME

CARON LEE RHIZOR

3. (b) Social Security Number

X

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white single6. (b) Name of husband or wife X7. Birth date of deceased (mo., day, yr.) Aug. 2nd. 1946

8. AGE: Years Months Days If less than one day

0 1 15 hrs. min.9. Birthplace Virginia
(Town, county, and state)10. Usual occupation X11. Industry or business X12. Name John D. Rhizor13. Birthplace Martinsferry, Ohio.14. Maiden name Mary Frances Makham15. Birthplace Virginia16. Informant Mrs. Eloise R. JonesAddress 10,000 Ga. Ave. Silver Spring17. Burial Date thereof 9-18-1946
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory Geo. Washington MemorialLocation Riggs Rd. Pr. Georges Co. Md.18. Funeral director Wm E PumphreyAddress Silver Spring, Md.19. Sept 17 46 Josephine M Schaeffer
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 19 46 at 10 A. M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept. 16 19 46 to Sept. 17 19 46and that I last saw h. ER alive on Sept 16 19 46Immediate cause of death Extreme pulmonary DURATION& Immortative diabetes 4 days

Due to

Due to

Other conditions Prenatal type infant, thecodepis weight 5 lbs.
(Include pregnancy within 8 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following: no

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE Wm A. Shonnon M.D.
M. D. or otherAddress 112 Carroll St. B.W. Date signed 9-17-46

MARGIN RESERVED FOR BINDING

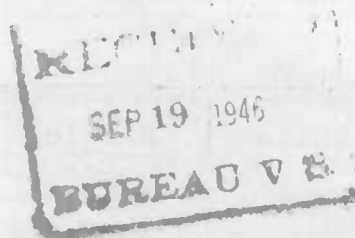
VS A15

9-45-15M

PLEASE WRITE PLAINLY WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Coroner ratified, OKed this certificate

W.A. Shoups M.D.



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 940

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 years
Hospital, institution, or street address where death occurred:
2 East Kirke Street
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
City or town Chevy Chase, Maryland
(If outside city or town limits, write RURAL and give nearest town)
Street No. 2 East Kirke Street
(If rural, give LOCATION)
2. (a) If veteran, name war World War I

3. (a) FULL NAME

ALBERT FLOYD ROTHBALLER

3. (b) Social Security Number

577-07-8547

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
6. (b) Name of husband or wife Helen Burns Rothballer
7. Birth date of deceased (mo., day, yr.) May 4, 1894 6. (c) If alive, give age 48 years
8. AGE: Years 52 Months 3 Days 29 If less than one day _____ hrs. _____ min.

9. Birthplace Syracuse, New York
(Town, county, and state)

10. Usual occupation Mgr. Branch House- West Electric

11. Industry or business

12. Name Frank C. Rothballer
13. Birthplace Syracuse, New York

14. Maiden name Jennette Griner
15. Birthplace Syracuse, New York

16. Informant Helen Burns Rothballer
Address 2 East Kirke St. Chevy Chase, Md

17. Burial Burial Date thereof Sept. 5, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington Nat'l Cemetery
Location Arlington, Virginia

18. Funeral director Wm Reuben Humphrey
Address 7557 Wis. Ave. Bethesda, Maryland

19. 9/4 46 Wm E Jones
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 3, 1946 at 3:45 am

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Dep med exam case 19. _____ to 19. _____
and that I last saw him _____ alive on 19. _____

Immediate cause of death

Coronary occlusion
Due to _____

Other conditions _____

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results _____
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)
Injured at home, farm, industry, public place (where?) _____
Means of injury _____ Injured at work?

23. SIGNATURE Frank J. Bruchart M.D.
St. Fred Exam M. D. or other
Address Washington Md Date signed 9-3-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

RECEIVED

SEP 5 1946

BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

09152

1. PLACE OF DEATH:

County MontgomeryCity or town Rural Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Fulham Hospital, Geo. Rd. Birth

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)Street No. 5515- Northfield Rd.
(If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

NANCY Russell

3. (b) Social Security Number

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

6. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

August 31- 1946

8. AGE:

Years

Months

Days

If less than one day

20 hrs. 45 min.9. Birthplace Bethesda Montgomery Maryland
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER

12. Name

John C. Russell

13. Birthplace

Bloomington Indiana

14. Maiden name

William

15. Birthplace

Bloomington Indiana

16. Informant

John C. Russell

Address

5515 Northfield Rd Bethesda Md

17.

(Burial, cremation, or removal, Which?)

Date thereof

9/3/46
(month) (day) (year)

Cemetery or crematory

Cedar Hill Cem -

Location

Maryland

18. Funeral director

W. A. Fisher, Pumphrey

Address

Bethesda, Md.

19.

(Date rec'd by registrar)

19 46Mr E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 2 1946, at 10 A. M

21. I CERTIFY that death occurred on the date above stated, that I attended deceased from

Aug. 31 1946 to Sept 2 1946.and that I last saw him/her alive on Sept. 2, 1946

Immediate cause of death

Cerebral
Congenital Heart Disease

DURATION

3 Days

Due to

Congenital

Due to

Other conditions

Spina Bifida
Vertical intervertebral disc protrusion
(Include pregnancy within 3 months of death) (Congenital)

Major findings of operations

Date of op.

Autopsy results

atelectasis, Congenital Heart Disease

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury

Injured at work?

23. SIGNATURE

Harold W. Hobart, M.D.

M. D. or other

Address

5402 Conn. aveDate signed 9/3/46Wash. D.C.

RECEIVED

SEP 5 1946

BUREAU V. B.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

09153

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 9 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 9 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
 State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1331 Kalmia Road, N. W.
 (If rural, give LOCATION)
 2.(a) If veteran, name war _____ ✓

3. (a) FULL NAME

SAPP, Earle Walter

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Mrs. Mabel W. Sapp7. Birth date of deceased (mo., day, yr.) 3 August 1890

8. AGE:	Years	Months	Days	If less than one day
	<u>56</u>	<u>1</u>	<u>7</u>hrs.min.

9. Birthplace New Jersey
(Town, county, and state)10. Usual occupation Veteran

11. Industry or business

12. Name Henry W. Sapp13. Birthplace N.J. (dec)14. Maiden name Marietta Smith15. Birthplace L.I. N.Y. (dec)16. Informant wife: Mrs. Mabel W. SappAddress 1331 Kalmia Road, N. W., Wash., D.C.17. burial Date thereof 9-12-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director S. H. Hines C. HillAddress 2901 14th St., N. W., Wash., D.C.19. 10 Sept. 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 10 Sept. 46 at 12:25A M

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 31 Aug. 46 to 10 Sept. 46
 and that I last saw him alive on 10 Sept. 46

Immediate cause of death Hemorrhage, cerebral
 DURATION 10 days

Due to Hypertension
 DURATION 7 yrs.

Due to arteriosclerosis

Other conditions congestive failure

(Include pregnancy within 8 months of death)

Major findings of operations _____ Date of op. _____

Autopsy results as above
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury car Thompson Injured at work? _____

23. SIGNATURE C. W. THOMPSON, Lt. Cdr. (MC) USNR

Address USNH Bethesda, Md. Date signed 9-10-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

11/4/46

RECEIVED
SEP 17 1946
BUREAU V. S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 93-2

09154

CERTIFICATE OF DEATH

Reg. Dist. No. 213

1. PLACE OF DEATH:

County MontgomeryCity or town Rockville, rural
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 30 years

Hospital, institution, or street address where death occurred:

(Halters)

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville, rural
(If outside city or town limits, write RURAL and give nearest town)Street No. (Halters)
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

MARIE SCHOLTZEL

3. (b) Social Security Number

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widowed

6. (b) Name of husband

Albert

7. Birth date of deceased (mo., day, yr.)

Aug. 20-1858

6. (c) If alive, give age years

8. AGE:

88

Years

Months

Days

If less than one day

hrs. min.

9. Birthplace

Washington, DC
(Town, county, and state)

10. Usual occupation

None

11. Industry or business

Unknown

12. Name

Germany

13. Birthplace

Unknown

14. Maiden name

Germany

15. Birthplace

Germany

16. Informant

Frederick Knott

Address

1104 - N Kentucky ST ARL Va

17. (Burial, cremation, or removal) Which?

Buried

Date thereof

Sep 3-1946
(month) (day) (year)

Cemetery or crematorium

Rock Creek Cemetery

Location

Washington, DC.

18. Funeral director

W. W. Chambers CO

Address

Washington, DC.19. 9-12 1946

(Date rec'd by registrar)

20. Bonifane Dupree

(Registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH September 1 1946, at 6:40 A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

1935 1946 to Sept 1 1946and that I last saw him alive on Sept 1 1946

Immediate cause of death

myocardial failure withcardiac decompensation

Due to

Chronic myocarditis

Due to

atherosclerosis

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

none

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Where did injury occur?

(City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE J. M. P. Lathrop M.D.Address Rockville, Md.Date signed 9/1/46

RECEIVED

SEP 13 1946

RECEIVED
SEP 13 1946

RECEIVED
SEP 14 1946
BUREAU V. B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

Female

5. Color or race

white

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

8164

hrs.

min.

9. Birthplace

Edwardstown, Michigan
(Town, county, and state)

10. Usual occupation

11. Industry or business

FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

16. Funeral director

Address

19.

(Date rec'd by registrar)

19

469/132pm E. Jones

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

200 Walnut St. N.W.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept-12, 1946 at 6²⁵ P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

20 August 1946 to 12 Sept. 1946and that I last saw him alive on 12 Sept. 1946

Immediate cause of death

Carcinoma, Neurolysis

DURATION

2-3 years

Due Primary in large intestine -

splenic flexure of colon

Due to

Cancer

Other conditions

(Include pregnancy within 8 months of death)

Major findings of operations

Neurolysis carcinoma of abdominal cavityDate of op. 9 Sept 1946Autopsy results Carcinoma large + small intestine - 2nd cancer

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

M. D. Jones
M. D. or other
Address Jakoma Park Rd. Date signed 13 Sept. 1946

RECEIVED
SEP 14 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 466

CERTIFICATE OF DEATH

09155

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... MontgomeryCity or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 10 days

Hospital, institution, or street address where death occurred:

USNaval Hospital, Bethesda, Md.How long in hospital or institution? 10 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...

City or town... Washington, D. C.

(If outside city or town limits, write RURAL and give nearest town)

Street No. 10 W Street, N. W.

(If rural, give LOCATION)

2(a) If veteran, name war 1st World War

3. (a) FULL NAME

SHEARER, Edgar Mapperson

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

married8. (b) Name of husband or wife... Mrs. Florence E. Shearer

B. (c) If alive, give age... years

7. Birth date of deceased (mo., day, yr.) 18 Feb. 18748. AGE: Years 72 Months 6 Days 29 If less than one day
..... hrs. min.9. Birthplace Scotland
(Town, county, and state)10. Usual occupation Veteran

11. Industry or business

12. Name... unknown13. Birthplace Scotland (dec)14. Maiden name... unknown15. Birthplace Scotland (dec)16. Informant wife: Mrs. Florence E. ShearerAddress 10 W Street, N. W., Wash., D.C.17. burial Date thereof 9-20-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory... Arlington NationalLocation... Arlington, Va.18. Funeral director... Hines Funeral HomeAddress 2901 Fourteenth St., N.W., Wash., D.C.19. Sept. 18 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 17 Sept. 46 at 4:30 P.21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 7 Sept. 46 to 17 Sept. 46
and that I last saw him alive on 17 Sept. 46

Immediate cause of death

SepticDue to... SepticDue to... Septic

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results... Carcinoma of stomach

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. DinsmoreAddress USNH Bethesda, Md.Date signed 9-18-46

RECEIVED
SEP 24 1945
BUREAU V. R.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct are especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1702

09156

CERTIFICATE OF DEATH

Reg. Dist. No. 216

1. PLACE OF DEATH:

County... Montgomery
 City or town... Bethesda (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 months, 13 days
 Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 6 months, 13 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Pa. County...
 City or town... Nazareth
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 423 S. Main Street
 (If rural, give LOCATION)
 2(a) If veteran, name war...

3. (a) FULL NAME

SHIMER, John Koch

3. (b) Social Security Number

4. Sex

male

5. Color or race

W-US

6. (a) Single, married, widowed, or divorced

single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

3-21-25

6. (c) If alive, give age... years

8. AGE:

2161hrs. min.

9. Birthplace

Pa.

(Town, county, and state)

10. Usual occupation

Navy

11. Industry or business

FATHER

12. Name Benjamin M. Shimer13. Birthplace Pa.

MOTHER

14. Maiden name Mayme Shimer15. Birthplace Pa

16. Informant

Father: Mr. Benjamin ShimerAddress 423 S. Main St., Nazareth, Pa.

17.

removal

(Burial, cremation, or removal. Which?)

Date thereof

9-23-46

(month) (day) (year)

Cemetery or crematory

Location

W. W. Chambers

18. Funeral director

Address 1400 Chapin St., N. W., Wash., D.C.

19.

9-2346

(Date rec'd by registrar)

Mary Charlotte Smith

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 22 Sept. 1946 at 6:45 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

9 March 1946 to 22 Sept. 1946and that I last saw him alive on 22 Sept. 1946Immediate cause of death... fracture of 6th
+ 7th cervical vertebrae with
trauma of cordDue to... (accidental)
auto accident

Due to...

Other conditions... Pneumonia

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

Same as above

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... accidental Date of 1-6-46Where did injury occur? near Nazareth, Pa. Pa.
 (City or town) (County) (State)Injured at home, farm, industry, public place (where?) highwayMeans of injury auto accident Injured at work? no

23. SIGNATURE

Frank J. Broschart M.D.

M. D. or other

Address... Smithsburg, Md. Date signed 9-23-46

9/28/46

RECEIVED
SEP 30 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (6)

CERTIFICATE OF DEATH

Reg. Dist. No. 223

1. PLACE OF DEATH:

County... MontgomeryCity or town... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

7705 Takoma Ave.

How long in hospital or institution?

3. (a) FULL NAME

Julia Jane Shira

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Widow6. (b) Name of husband or wife... William Francis Shira

6. (c) If alive, give age... years

7. Birth date of

deceased (mo., day, yr.)

6 - 23 - 1868

8. AGE:

Years

78

Months

2

Days

27

If less than one day

hrs.

min.

9. Birthplace... Tidioute Warren Co., Penna
(Town, county, and state)10. Usual occupation... Housewife

11. Industry or business

12. Name... James Cheers13. Birthplace... New York State14. Maiden name... Harriet Bristol15. Birthplace... Connecticut16. Informant... D.R. ChristieAddress... 7705 Takoma Ave., Takoma Park, Md17. Burial Date thereof... 9 - 20 - 46
(Burial, cremation, or removal, Which?) (month) (day) (year)Cemetery or crematory... North Side CemeteryLocation... Butler, Penna.18. Funeral director... Wm. E. Humphrey, Inc.Address... Blue Spring Road19. Sept 20 19 46
(Date rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... Maryland County... MontgomeryCity or town... Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 7705 Takoma Ave.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

None

MEDICAL CERTIFICATION

20. DATE OF DEATH 20 Sept 19 46 at 9⁰⁵ A. M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

May 1 19 46 to 20 Sept. 19 46and that I last saw him alive on 13 Sept. 19 46

Immediate cause of death

(Respiratory failure)Myocardial infarction + strokeDue to arteriosclerosis, generalizedDue to Nichols Mellitus

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op. LAutopsy results None

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... W. E. Humphrey, Inc. M. D. or otherAddress... 112 Willow Ave. Date signed 20 Sept 46
Takoma Park, Md.

DURATION

3 months8-10 years12-15 years

DENGLER - ATWELL FUNERAL HOME.

Chas. J. Dengler

W. Jefferson St.

Butler Pa

RECEIVED

SEP 23 1946

BUREAU V A

M

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (37-2)

09158

CERTIFICATE OF DEATH

★ Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery County
 City or town Takoma Park, Maryland
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? thirty-nine days
 Hospital, institution, or street address where death occurred:
Washington Sanatorium & Hospital
 How long in hospital or institution? thirty-nine days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State DC County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 3833 Fulton Street
 (If rural, give LOCATION)
 2. (a) If veteran, name war No ✓

3. (a) FULL NAME

Charles Melvin Shorey

3. (b) Social Security Number

4. Sex Male 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife Mrs. C. B. Shorey
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) September 1, 1863 (F)
 8. AGE: Years 80? Months 0 Days 16 If less than one day _____ hrs. _____ min.

9. Birthplace Albion, Maine
 (Town, county, and state)
 10. Usual occupation Retired
 11. Industry or business _____

12. Name _____
 13. Birthplace _____
 14. Maiden name _____
 15. Birthplace _____
 (not available)

16. Informant Washington San. & Hospital records
 Address Takoma Park, D.C., Maryland
 17. Removed Date thereof 9-17-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)

Cemetery or crematory Washington D.C.
 Location The 8th Street B.C.

18. Funeral director The 8th Street B.C.
 Address 2901-15th St. N.W.

19. Sept 17 1946
 (Date rec'd by registrar) Registrar John M. Dolt

MEDICAL CERTIFICATION

20. DATE OF DEATH September 17 1946 at 11:30 AM
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from January 15 1946 to Sept 17 1946
 and that I last saw him alive on Sept 17 1946

Immediate cause of death _____ DURATION _____
Coronary Occlusion Terminal

Due to arteriosclerosis _____ years

Due to _____ years

Other conditions enlarged Prostate _____ years
 (Include pregnancy within 3 months of death)

Major findings of operations enlarged Prostate _____
 Date of op. _____

Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)
 Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Robert A. Fare, M.D. M. D. or other _____
 Address Takoma Park, Md. Date signed 9/17/46

RECEIVED

SEP 20 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 46-11

CERTIFICATE OF DEATH

09159 213
Reg. Dist. No.

1. PLACE OF DEATH:
County Montgomery
City or town Rockville RD #3
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? LIFE
Hospital, institution, or street address where death occurred:
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)
State Rockville County Montgomery
City or town Rockville RD #3
(If outside city or town limits, write RURAL and give nearest town)
Street No. Avery Road
(If rural, give LOCATION)
2.(a) If veteran, name war

3. (a) FULL NAME
Ulysses Grant Smith

3. (b) Social Security Number

4. Sex M/R 5. Color or race colored 6. (a) Single, married, widowed, or divorced widowed

6. (b) Name of husband or wife Elissa Smith

7. Birth date of deceased (mo., day, yr.) November 16, 1872 6. (c) If alive, give age years

8. AGE: Years 73 Months 10 Days 25 It less than one day
hrs. min.

8. Birthplace Rockville, Montgomery, Md.
(Town, county, and state)

10. Usual occupation FARMER

11. Industry or business OWN FARM

12. Name BENJAMIN SMITH

13. Birthplace Rockville

14. Maiden name Jane Smith

15. Birthplace Rockville

16. Informant Mrs. Hill, Daughter

Address 722 HENRY ST. N.W. P.C.

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof Sept 11, 1946
(month) (day) (year)
Cemetery or crematory Lincoln Park Cem.

Location Rockville, Md.

18. Funeral director R. L. Sengarden

Address Rockville, Md.

19. 9-11 46 Betty Jane Snyder
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 19, 1946 at 5:50 AM

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 1938 to Sept 9, 1946
and that I last saw him alive on Sept 8, 1946

Immediate cause of death CARCINOMA OF LIVER DURATION 6 M.

Due to Metastatic FROM

Due to CARCINOMA OF RECTUM 8 YRS.

Other conditions Other metastatic LESIONS

(Include pregnancy within 3 months of death)

Major findings of operations REMOVAL OF
CARCINOMA OF RECTUM Date of op. 1938

Autopsy results PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of Injury Injured at work?

23. SIGNATURE Smith with R.B. M. D. or other
Address Rockville, Md Date signed 9/19/46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASTING STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

STATE OF MASSACHUSETTS

DEATH RECORD

RECEIVED
SEP 12 1946
BUREAU V B

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (99)

CERTIFICATE OF DEATH

09160

Reg. Dist. No. 214

1. PLACE OF DEATH:

County Spencerville Montgomery
 City or town Spencerville
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgomeryCity or town Spencerville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. _____

(If rural, give LOCATION)

2.(a) If veteran, name war no

3. (a) FULL NAME

Emma Taylor Stabler

3. (b) Social Security Number

no

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female white single

6. (b) Name of husband or wife no7. Birth date of deceased (mo., day, yr.) Sept. 18 - 18688. AGE: Years Months Days If less than one day
77 11 16 _____ hrs. _____ min.9. Birthplace Sandy Spring Md.
 (Town, county, and state)10. Usual occupation Artist11. Industry or business "12. Name Robert Miller Stabler13. Birthplace Sandy Spring, Md.14. Maiden name Hannah Taylor15. Birthplace Ta.16. Informant Robert J. StablerAddress 3117 Cambridge Place D.C.17. Burial Date thereof Sept 5, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Truagh Burying GroundsLocation Sandy Spring Md.18. Funeral director Joseph F. BuchananAddress 3034 - M St. N.W. Wash. D.C.19. Sept 4 19 46 Josephine W. Schaeff
 (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 3 - 1946, at 9:30 P.M.21. I CERTIFY that death occurred on the date above stated; that I attended deceased from July 28 - 1946, to Sept 2 - 1946, and that I last saw him alive on Sept 2 - 1946Immediate cause of death Gangrene of both legs - 36 daysDue to Hyperkalemia +Underteritis of pitDue to crans

Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations noAutopsy results no

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury _____ Injured at work? _____

23. SIGNATURE Charles W. Hulse M. D.Address Sandy Spring Md. Date signed 9/3/46

REC-11111
SEP 9 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (240)

CERTIFICATE OF DEATH

09161

Reg. Dist. No. 716

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda Md
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

Suburban HospHow long in hospital or institution? 24 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Rockville
(If outside city or town limits, write RURAL and give nearest town)Street No. R.F.D. 4
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (a) FULL NAME

Marie Hermania Brand Staedter

3. (b) Social Security Number

None

4. Sex

Female

5. Color or race

White

6. (a) Single, married, widowed, or divorced

Single

6. (b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.)

June 23, 1875

6. (c) If alive, give age years

8. AGE:

Years

Months

Days

If less than one day

71229

hrs.

min.

9. Birthplace

Hoboken, New Jersey
(Town, county, and state)

10. Usual occupation

none

11. Industry or business

MOTHER FATHER

12. Name William Frederick Brandstaedter13. Birthplace Hanover, Germany14. Maiden name Rosa Grabus15. Birthplace Bromberg, Germany16. Informant Sister, Mrs. Irene KavanaughAddress R.F.D. 4, Rockville, Md.

17.

Burial
(Burial, cremation, or removal. Which?)Date thereof Sept. 24, 1946
(month) (day) (year)

Cemetery or crematory

Mt. Olivet

Location

Hanover, York Co., Pa.

18. Funeral director

Warner & E. Humphrey

Address

Silver Spring, Md.

19.

9/21

19

46Wm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 21 19 46 at 2:40 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

27 August 19 46 to 21 Sept 19 46and that I last saw him alive on 20 Sept 19 46

Immediate cause of death

Septicemia, hemolytic staph.

DURATION

July 11, 46

Due to

Due to

Other conditions

Cardiac decompensation
acceleration of aortic atherosclerosis
(Include pregnancy within 3 months of death)12 Sept 4618 Sept 46

Major findings of operations

Date of op.

Autopsy results

(NONE)

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

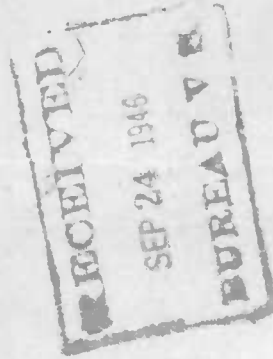
23. SIGNATURE

A. N. Levenson M.D.

M. D. or other

Address

Suburban Hosp
BethesdaDate signed 21 Sept 46



MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 1248

CERTIFICATE OF DEATH

09162

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 23 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 23 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Md. County _____
City or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)
Street No. 733 Easley Street
(If rural, give LOCATION)
2.(a) If veteran, name war _____

3. (a) FULL NAME

STAUFFER, Jack Harned

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6.(a) Single, married, widowed, or divorced MARRIED

6.(b) Name of husband or wife Mrs. Kathleen Stauffer
6.(c) If alive, give age _____ years

7. Birth date of deceased (mo., day, yr.) Aug. 12, 1897
8. AGE: Years 49 Months 0 Days 24 If less than one day _____ hrs. _____ min.

9. Birthplace Penn.
(Town, county, and state)

10. Usual occupation Veteran

11. Industry or business _____

FATHER 12. Name Henry Stauffer
13. Birthplace Penn. (dec.)

MOTHER 14. Maiden name Frances Harned
15. Birthplace Penn. (dec.)

16. Informant wife: Mrs. Kathleen Stauffer
Address 733 Easley St., Silver Springs, Md.

17. burial Date thereof 9-9-46
(Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory Arlington National
Location Arlington, Va.

18. Funeral director W. W. Chambers
Address 1400 Chapin St., N. W., Wash., D.C.

19. 9-6 19 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

2D. DATE OF DEATH 6 Sept. 19 46 at 3:25 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 15 Aug. 19 46 to 6 Sept. 19 46
and that I last saw him alive on 6 Sept. 19 46

Immediate cause of death Peritonitis, Liver atrophy
DURATION 49 hrs.
Due to Peritonitis, Liver atrophy 6 hrs.

Due to _____
Other conditions _____

(Include pregnancy within 3 months of death)

Major findings of operations _____
Date of op. _____
Autopsy results Peritonitis, Liver atrophy
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide _____ Date of _____
Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____
Manner of injury _____ Injured at work? _____

23. SIGNATURE W. Dinsmore, Jr., Lt. Col. (MC) USN
Address USNH Bethesda, Md. Date signed 9-6-46

MARGIN RESERVED FOR BINDING

VS A15 9-45-15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9/12/46

RECEIVED
SEP 13 1946
BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

942

09163

CERTIFICATE OF DEATH

Reg. Dist. No. 316

1. PLACE OF DEATH:

County MontgomeryCity or town Glen Echo, Md.
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 25 yrs

Hospital, institution, or street address where death occurred:

5432 Mohican Rd.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Glen Echo, Md.
(If outside city or town limits, write RURAL and give nearest town)Street No. 5432 Mohican Rd.
(If rural, give LOCATION)

2(a) If veteran, name war

3. (a) FULL NAME

Nellie R. Stevens

3. (b) Social Security Number

4. Sex Female 5. Color or race white 6. (a) Single, married, widowed, or divorced Widowed

8. (b) Name of husband or wife

8. (c) If alive, give age _____ years

7. Birth date of

deceased (mo., day, yr.)

1872

8. AGE:

Years

Months

Days

If less than one day

7422

hrs.

min.

9. Birthplace

Brownstown, Pa.
(Town, county, and state)

10. Usual occupation

house wife

11. Industry or business

FATHER

12. Name

James Stevens

13. Birthplace

Pa.

MOTHER

14. Maiden name

Annis E. Ryan

15. Birthplace

Pa.

16. Informant

Helen Kinnard

Address

5432 Mohican Rd. Glen Echo, Md.

17.

(Burial, cremation, or removal? Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Rock Creek Cem.

Location

Wash. D.C.

18. Funeral director

Address

The S H Jones Co
2901-14th St NW

19.

(Date rec'd by registrar)

19.

9/16/46 Hm E Jones

Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 16 1946 at 1:20 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 16 1946 to 19 1946
and that I last saw him alive on Exam case 1946

Immediate cause of death

DURATION

Coronary occlusion

Due to

Due to

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

Dr. J. P. Roschert M.D.
Dr. med. Exam M. D. or other
Address Dr. P. Roschert Date signed 9/16/46

CERTIFICATE OF DEATH

DECEASED PERSON'S NAME

DATE OF DEATH

MEDICAL CERTIFICATION

DATE OF DEATH

SEP 18 1946

BUREAU OF VITALS

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (121)

CERTIFICATE OF DEATH

Reg. Diat. No. 216

09164

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 6 Days
 Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 6 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington County D.C.
 City or town Washington, D.C.
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 5709 5th St. N.W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war World War I ✓

3. (a) FULL NAME

Gilmore Wilson THOMPSON

3. (b) Social Security Number

4. Sex male 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married
 6. (b) Name of husband or wife Mrs. Viola B. Thompson
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) May 20 1898
 8. AGE: Years 48 Months 3 Days 19 If less than one day _____ hrs. _____ min.

9. Birthplace Md.
 (Town, county, and state)
 10. Usual occupation Veteran
 11. Industry or business
 FATHER 12. Name Oliver W. Thompson
 13. Birthplace Md.
 MOTHER 14. Maiden name Laura Claggett (doc)
 15. Birthplace Md.

16. Informant Mrs. Viola B. Thompson
 Address 5709 5th St. N.W. Wash., D.C.
 17. burial Date thereof 9-11-46
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National
 Location Arlington, Va.

18. Funeral director S. H. Hines Co. S.O.P.
 Address 1901 14th St. N.W. Wash., D.C.
 19. 9 Sept 1946
 (Date rec'd by registrar) Mary Charlotte Smith
 Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 8 Sept 19 46 at 8:05 p.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 2 19 46 to Sept. 8 19 46
 and that I last saw him alive on 8 Sept. 19 46

Immediate cause of death apudectes Acute
 DURATION 1 hr

Due to _____

Due to _____

Other conditions Generalized peritonitis

(Include pregnancy within 3 months of death)

Major findings of operations _____

Date of op. _____

Autopsy results _____

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide _____ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of injury _____ Injured at work? _____

23. SIGNATURE Frank S. ASHBURN, Lt. Cdr. (MC) USN

M. D. or other

Address USNH Bethesda, Md. Date signed 9-9-46

MARGIN RESERVED FOR BINDING

9-45-15

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9/14/46

RECEIVED

SEP 17 1946

BUREAU V S

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09165

Reg. Dist. No. 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda, Md. (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death?
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 18 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Washington, D. C. County Washington, D. C.
City or town Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 206 H Street, S. W.
(If rural, give LOCATION)
2. (a) If veteran, name war World War I

3. (a) FULL NAME

Parris (n) THORNTON

3. (b) Social Security Number

4. Sex male 5. Color or race Col-US 6. (a) Single, married, widowed, or divorced single

6. (b) Name of husband or wife

6. (c) If alive, give age 18 years

7. Birth date of 20 Feb. 1891
deceased (mo., day, yr.)

8. AGE: Years 55 Months 6 Days 24 It less than one day
hrs. min.

9. Birthplace Washington, D. C.
(Town, county, and state)

10. Usual occupation Veteran

11. Industry or business

12. Name Edward Thornton

13. Birthplace Va. (dec.)

14. Maiden name Anna Hart

15. Birthplace Va. (dec)

16. Informant sister: Mrs. Edna Gillis

Address 206 H St., S.W., Wash., D.C.

17. burial Date thereof 9-19-46
(Burial, cremation, or removal, Which?) (month) (day) (year)

Cemetery or crematory Arlington National Cemetery

Location Arlington, Va.

18. Funeral director Barnes & Mathews (now)

Address 614 4th Street, SW, Washington, D.C.

19. 15 Sept. 46 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 14 Sept. 1946 at 2:35 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 28 Aug. 1946 to 14 Sept. 1946
and that I last saw him alive on 14 Sept. 1946

Immediate cause of death Massive pulmonary hemorrhage
Due to Ruptured aortic aneurysm
Due to arteriosclerosis (cardiovascular)
Other conditions
(Include pregnancy within 3 months of death)

Major findings of operations Ruptured aortic aneurysm
Date of op.
Autopsy results Ruptured aortic aneurysm
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
Accident, suicide, or homicide. Date of
Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)
Means of injury J.B. Shuler Injured at work?
J.B. Shuler
23. SIGNATURE C. H. C. SMITH, Comdr. (MC) USNR
M. D. or other
Address USNH Bethesda, Md. Date signed 9-15-46

MARGIN RESERVED FOR BINDING

VS A15

9.45.15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age especially important. Physicians: please write the causes of death clearly and legibly.

9/24/46

RECEIVED
SEP 26 1946
BUREAU V.S.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09166

Reg. Dist. No. 223

1. PLACE OF DEATH:

County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? ---

Hospital, institution, or street address where death occurred:

629 Elm AvenueHow long in hospital or institution? ---

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County MontgomeryCity or town Takoma Park
(If outside city or town limits, write RURAL and give nearest town)Street No. 629 Elm Avenue
(If rural, give LOCATION)2.(a) If veteran, name war ---

3. (a) FULL NAME

FLORENCE V. WAGELEY

3. (b) Social Security Number

None

4. Sex 5. Color or race 6.(a) Single, married, widowed, or divorced

Female White Widowed6.(b) Name of husband late Mann F. Wageley6.(c) If alive, give age --- years7. Birth date of deceased (mo., day, yr.) May 26, 18568. AGE: Years Months Days If less than one day
90 3 19 --- hrs. --- min.9. Birthplace Berryville, Virginia
(Town, county, and state)10. Usual occupation none11. Industry or business ---12. Name Peter Light13. Birthplace Virginia14. Maiden name Carolyn Helphenstein15. Birthplace Virginia16. Informant Mrs. Gladys C. LathamAddress 629 Elm Ave., Takoma Park, Md.17. Burial Date thereof Sept. 18, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Fort Lincoln CemeteryLocation Bladensburg Road, Md. -- D.C. Line18. Funeral director Warner E. PumphreyAddress Silver Spring, Maryland19. 9-17 19 46
(Date rec'd by registrar) Registrar [Signature]

MEDICAL CERTIFICATION

20. DATE OF DEATH September 15th 19 46, at 10:00 pm21. I CERTIFY that death occurred on the date above stated; that I attended deceased from September 14 19 46 to Sept. 14 19 46 and that I last saw h. E.R. alive on Sept. 14 19 46Immediate cause of death Cardiac dilatation DURATION SuddenDue to Chronic myocarditis of old ageDue to ---Other conditions marked emaciation
(Including pregnancy within 8 months of death)Major findings of operations --- Date of op. ---Autopsy results ---
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide --- Date of ---

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) ---Means of injury --- Injured at work? ---23. SIGNATURE Wm. A. Shuman Jr. M. D. or other ---Address 113 Carroll St. N.W. Date signed Sept. 15, '46

CERTIFICATE OF DEATH

THE FOLLOWING INFORMATION IS FOR OFFICIAL USE ONLY

NAME OF DECEASED

DATE OF DEATH

PLACE OF DEATH

TIME OF DEATH

CAUSE OF DEATH

MANNER OF DEATH

REPORTING PHYSICIAN

NAME OF PHYSICIAN

ADDRESS OF PHYSICIAN

CITY AND STATE OF PHYSICIAN

DATE OF REPORT

SIGNATURE OF PHYSICIAN

PRINTED NAME OF PHYSICIAN

DEGREE OF PHYSICIAN

BOARD OF MEDICAL EXAMINERS

CITY AND STATE OF PHYSICIAN

DATE OF REPORT

SIGNATURE OF PHYSICIAN

PRINTED NAME OF PHYSICIAN

DEGREE OF PHYSICIAN

BOARD OF MEDICAL EXAMINERS

CITY AND STATE OF PHYSICIAN

DATE OF REPORT

SIGNATURE OF PHYSICIAN

PRINTED NAME OF PHYSICIAN

DEGREE OF PHYSICIAN

BOARD OF MEDICAL EXAMINERS

CITY AND STATE OF PHYSICIAN

DATE OF REPORT

RECEIVED
SEP 20 1946
BUREAU V 2

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50

CERTIFICATE OF DEATH

Reg. Dist. No. 217

1. PLACE OF DEATH:

County Montgomery
 City or town Olney, Maryland
 (If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

The Montgomery County General Hospital Inc.

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Maryland County Montgomery
 City or town Rockville
 (If outside city or town limits, write RURAL and give nearest town)

Street No. 1005 Debeek Drive
 (If rural, give LOCATION)

2.(a) If veteran, name war

3. (a) FULL NAME

Mrs. Edna A. Waite

3. (b) Social Security Number

None

4. Sex 5. Color or race 6. (a) Single, married, widowed, or divorced

Female White Widow

6. (b) Name of husband or wife Augustus Waite7. Birth date of deceased (mo., day, yr.) July 12, 1878

8. AGE: Years Months Days It less than one day

68 2 16 hrs. min.

9. Birthplace Thomaston, Connecticut
(Town, county, and state)10. Usual occupation Retired Housewife

11. Industry or business

12. Name Elmer Alcott13. Birthplace Connecticut14. Maiden name Adelaide Johnson15. Birthplace Connecticut16. Informant Hospital recordsAddress Olney Md.17. Removal Funeral Date thereof Sept 29, 1946
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Hillside CemeteryLocation Jorrington, Litchfield Co., Conn.18. Funeral director Wm. E. PumphreyAddress Silver Spring, Md.19. Sept 29, 1946 Dr. J. D. Lawler
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH September 28 1946 at 2:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

March 5, 1946 to Sept. 28 1946and that I last saw him alive on Sept. 28 1946Immediate cause of death Carcinoma of left breast with generalized metastasesDue to Radical removal of breast, Oct. 1945Due to X-ray therapy

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations

Date of op.

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Maona of injury Injured at work?

23. SIGNATURE J. M. Lathum, M.D.
M. D. or otherAddress Rockville, Md. Date signed 9/28/46

(Buried Permit issued by Silver Spring Registrar)

RECEIVED

OCT 18 1946

BUREAU OF

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 50 X

CERTIFICATE OF DEATH

09167

Reg. Dist. No. 223

1. PLACE OF DEATH:

County Montgomery
 City or town Takoma Park Md.
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 8 days
 Hospital, institution, or street address where death occurred:
Washington Sanitarium and Hospital
 How long in hospital or institution? 8 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State D.C. County _____
 City or town Washington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1712 Irving St N.W.
 (If rural, give LOCATION)
 2. (a) If veteran, name war _____

3. (a) FULL NAME

Mrs Annie Warren

3. (b) Social Security Number

4. Sex Female 5. Color or race White 6. (a) Single, married, widowed, or divorced Married
 6. (b) Name of husband or wife William S. Warren
 6. (c) If alive, give age _____ years
 7. Birth date of deceased (mo., day, yr.) Sept. 25, 1893
 8. AGE: Years 53 Months _____ Days 5 If less than one day _____ hrs. _____ min.

9. Birthplace Dunbar Penn.
 (Town, county, and state)
 10. Usual occupation House wife
 11. Industry or business Own home

MOTHER FATHER
 12. Name Albert Humphries
 13. Birthplace Bilsdon England
 14. Maiden name Margaret Rutherford
 15. Birthplace Bilsdon England
 16. Informant Hospital Records
 Address _____

17. Burial Date thereof Oct. 2, 1946
 (Burial, cremation, or removal. Which?) (month) (day) (year)
 Cemetery or crematory Arlington National Cem.
 Location Arlington, Va
 18. Funeral director The S. H. Dennis Co.
 Address 2901-14 St. N.W. D.C.
 19. Sept. 30, 1946 Registrar J. M. Reed
 (Date read by registrar)

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/30 1946 at 7:55 A.M.
 21. I CERTIFY that death occurred on the date above stated; that I attended deceased from 9/29 1946 to 9/30 1946
 and that I last saw him alive on 9/29 1946

Immediate cause of death Metastatic carcinoma to
spleen, ribs & liver
 Due to primary adenocarcinoma of left
breast
 Due to _____
 Other conditions _____
 (Include pregnancy within 8 months of death)

DURATION

4 months1 year

Major findings of operations _____ Date of op. _____
 Autopsy results _____
 PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:
 Accident, suicide, or homicide _____ Date of _____
 Where did injury occur? (City or town) (County) (State)
 Injured at home, farm, industry, public place (where?) _____
 Means of injury _____ Injured at work?

23. SIGNATURE Paul Benjamin, M.D.
 M. D. or other _____
 Address Arthur, 14 St Date signed 9/30/46

RECEIVED

OCT 2 1946

BUREAU V S

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No. 216

09168

1. PLACE OF DEATH:

County Montgomery
 City or town Bethesda, Md. (rural)
 (If outside city or town limits, write RURAL and give nearest town)
 How long in above place of death? 16 Days
 Hospital, institution, or street address where death occurred:
U.S. Naval Hospital, Bethesda, Md.
 How long in hospital or institution? 16 Days

2. USUAL RESIDENCE (HOME) OF DECEASED:
(For newborn infants give residence of mother)

State Virginia County Arlington
 City or town Arlington
 (If outside city or town limits, write RURAL and give nearest town)
 Street No. 1615 Quincy St.
 (If rural, give LOCATION)
 2.(a) If veteran, name war. ☒

3. (a) FULL NAME

Lucy (n) WEAVER

3. (b) Social Security Number

4. Sex Female 5. Color or race W-US 6. (a) Single, married, widowed, or divorced married

6. (b) Name of husband or wife R.E. Weaver Lt. (HC) USN Ret.

6. (c) If alive, give age..... years

7. Birth date of deceased (mo., day, yr.) 15 January 1879

8. AGE: Years 67 Months 7 Days 21 If less than one day
hrs.min.

9. Birthplace Ohio
(Town, county, and state)10. Usual occupation Housewife

11. Industry or business

12. Name Benjamin Taylor (dec.)13. Birthplace England14. Maiden name Louise Betz (dec.)15. Birthplace Germany16. Informant R.E. Weaver Lt. (HC) Ret.Address 1615 Quincy St. Arlington, Va.17. burial Date thereof 9-9-46
(Burial, cremation, or removal. Which?) (month) (day) (year)Cemetery or crematory Arlington NationalLocation Arlington, Va.18. Funeral director Ives Funeral HomeAddress Arlington, Va.19. 5 Sept 1946 Mary Charlotte Smith
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 5 Sept 1946 4:33 a.m.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from
20 Aug. 1946 to 5 Sept. 1946
 and that I last saw him er alive on 5 Sept. 1946

Immediate cause of death Hypertensive heart disease DURATION 10 years

Due to.....

Due to.....

Other conditions.....

(Include pregnancy within 3 months of death)

Major findings of operations.....

Date of op.

Autopsy results Cor. Thrombosis with myocardial infarction

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide..... Date of.....

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury g.s. Barnes Injured at work?23. SIGNATURE T. S. BARNES, Lt.Cdr. (MC) USN

M. D. or other

Address USNH Bethesda, Md. Date signed 9-5-46

RECEIVED

SEP 13 1946

BUREAU V D

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

09170

216

Reg. Dist. No.

1. PLACE OF DEATH:

County... Montgomery
City or town... Bethesda (rural)
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 7 months, 27 days
Hospital, institution, or street address where death occurred:
US Naval Hospital, Bethesda, Md.
How long in hospital or institution? 7 months, 27 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State... County...
City or town... Washington, D. C.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 1840 T Street, S.E.
(If rural, give LOCATION)
2. (a) If veteran, name war...

3. (a) FULL NAME

Edward Oscar WHITE

3. (b) Social Security Number

4. Sex... male 5. Color or race... W-DS 6. (a) Single, married, widowed, or divorced... married

6. (b) Name of husband or wife... Mrs. Helene E. White

7. Birth date of deceased (mo., day, yr.)... 2 Dec. 1898 8. (c) If alive, give age... years

8. AGE: Years... 47 Months... 9 Days... 12 If less than one day... hrs. min.

9. Birthplace... Mich. (Town, county, and state)

10. Usual occupation... Veteran

11. Industry or business

FATHER 12. Name... Charles White 13. Birthplace... N.Y. dec.

MOTHER 14. Maiden name... Lenora Craque 15. Birthplace... Mich. dec.

16. Informant... wife: Mrs. Helene E. White Address... 1840 T Street, S. E.

17. burial Date thereof... 9-18-46 (Burial, cremation, or removal. Which?) (month) (day) (year)
Cemetery or crematory... Arlington National
Location... Arlington, Va.

18. Funeral director... Chambers Undertakers Address... 517 11th St., S.E., Washington, D.C.

19. 15 Sept. 1946 Mary Charlotte Smith (Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH... 14 Sept. 1946 at 11:35 P.

21. I CERTIFY that death occurred on the date above stated: that I attended deceased from 17 January 1946 to 11 Sept. 1946 and that I last saw him alive on 14 Sept. 1946

Immediate cause of death... Adenocarcinoma, Sigmoid Colon DURATION... 18 months

Due to...

Due to...

Other conditions...

(Include pregnancy within 3 months of death)

Major findings of operations... Partial obstruction sigmoid colon Date of op. 6-30-45
Autopsy result... Biopsy - adenocarcinoma inside 2 sigmoid
PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide... Date of...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury Injured at work?

23. SIGNATURE... R. N. GRANT, Comdr. (MC) USN

M. D. or other

Address... USNH Bethesda, Md. Date signed... 9-15-46

MARGIN RESERVED FOR BINDING

I

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

9/19/46

RECEIVED

SEP 23 1946

BUREAU V. A.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

Evidence for the change of
name and age is shown on

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 746

CERTIFICATE OF DEATH

09171

Reg. Dist. No. 216

FILM No. I O 8 NOV - 7 1946

1. PLACE OF DEATH:

County Montgomery County

City or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death? 2 days

Hospital, institution, or street address where death occurred:
Suburban Hospital

How long in hospital or institution? 2 days

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State Washington D.C. County ...

City or town Washington D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No. 3100 Conn Ave.
(If rural, give LOCATION)

2(a) If veteran, name war ✓

3. (a) FULL NAME

Mrs. Minnie Bole White

3. (b) Social Security Number

4. Sex

F

5. Color or race

W

6. (a) Single, married, widowed, or divorced

married

6. (b) Name of husband or wife Geo White

7. Birth date of deceased (mo., day, yr.) July 6 1875

6. (c) If alive, give age 18 years

8. AGE: Years 69 Months 7 Days 16 If less than one day ... hrs. ... min.

9. Birthplace Ireland
(Town, county, and state)

10. Usual occupation House wife

11. Industry or business

12. Name Andrew Bole

13. Birthplace Ireland

14. Maiden name Mary Ann White

15. Birthplace Ireland

18. Informant Hospital Record

Address Suburban Hosp. Bethesda

17. (Burial, cremation, or removal. Which?) Burial Date thereof 9/24/46
(month) (day) (year)

Cemetery or crematory Rock Creek Cem

Location Washington D.C.

18. Funeral director Joseph ...

Address 1960 Penna Ave N.W.

19. 9-22-46 19 ... Registrar ...

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept. 22 19 46 at 11:20 A.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1945 19 ... to Sept. 21 19 46

and that I last saw her alive on Sept. 21 19 46

Immediate cause of death Cerebral Thrombosis -

(Recurrent, terminal)

Due to ...

Due to ...

Due to ...

Due to ...

Other conditions Hypertension, until

present illness.

(Include pregnancy within 3 months of death)

Major findings of operations ...

Date of op. ...

Autopsy results ...

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ... Date of ...

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?)

Means of injury ... Injured at work? ...

23. SIGNATURE Karl ... M. D. or other ...

Address ... Date signed ...

RECEIVED

OCT 2 1946

BUREAU V B

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore 749

CERTIFICATE OF DEATH

Reg. Dist. No. 09172 216

1. PLACE OF DEATH:

County Montgomery
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
How long in above place of death? 1 yr.
Hospital, institution, or street address where death occurred:
5611 Sonoma Rd.
How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)
State Maryland County Montgomery
City or town Bethesda Md.
(If outside city or town limits, write RURAL and give nearest town)
Street No. 5611 Sonoma Rd.
(If rural, give LOCATION)
2.(a) If veteran, name war World War II

3.(a) FULL NAME

Alton E. Wise Jr.

3.(b) Social Security Number

4. Sex Male 5. Color or race White 6.(a) Single, married, widowed, or divorced Married

8.(b) Name of husband or wife Sarah Ann
8.(c) If alive, give age 26 years

7. Birth date of deceased (mo., day, yr.) Aug. 29, 1911

8. AGE: Years 35 Months 0 Days 3 If less than one day
hrs. min.

9. Birthplace Elba, Alabama
(Town, county, and state)

10. Usual occupation Interstate Commerce Com. - Lawyer

11. Industry or business

12. Name Alton E. Wise, Sr.

13. Birthplace Elba, Alabama

14. Maiden name Maie Wise

15. Birthplace Elba, Alabama

18. Informant Mr. Alton E. Wise, Sr.

Address 7810 Greenway Blvd, Dallas, Texas

17. Burial (Burial, cremation, or removal, Which?) Burial Date thereof 9/4/46
(month) (day) (year)

Cemetery or crematory Columbia Gardens, Arlington

Location Arlington Va.

18. Funeral director W. R. Reuben Humphrey

Address Bethesda Md.

19. 9/2 46 3M E. J. Allen
(Date rec'd by registrar) Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH Sept 1 1946, at 5:45 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from Sept. 1st to Sept. 1st

and that I last saw him alive on Sept. 1st

Immediate cause of death Coronary occlusion

Due to Coronary occlusion

Other conditions Coronary occlusion

Due to Coronary occlusion

Other conditions Coronary occlusion

(Include pregnancy within 8 months of death)

Major findings of operations Coronary occlusion

Date of op. Sept 1

Autopsy results Coronary occlusion

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide Accident Date of Sept 1

Where did injury occur? (City or town) (County) (State)

Injured at home, farm, industry, public place (where?) (City or town) (County) (State)

Means of injury Car Injured at work?

23. SIGNATURE Frank J. Bronhart M.D.

Address Bethesda Md. Date signed 9-1-46

MARGIN RESERVED FOR BINDING

VS A15

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MASSACHUSETTS STATE DEPARTMENT OF HEALTH

CERTIFICATE OF DEATH

SEP 4 1946
BUREAU V.B.

PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore

CERTIFICATE OF DEATH

Reg. Dist. No.

216

1. PLACE OF DEATH:

County MontgomeryCity or town Bethesda
(If outside city or town limits, write RURAL and give nearest town)

How long in above place of death?

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

3. (a) FULL NAME

4. Sex

male

5. Color or race

white widower

6. (a) Single, married, widowed, or divorced

6. (b) Name of husband or wife

7. Birth date of

deceased (mo., day, yr.)

8. AGE:

Years

Months

Days

If less than one day

62227hrs.min.

9. Birthplace

Washington, D.C.
(Town, county, and state)

10. Usual occupation

11. Industry or business

MOTHER FATHER

12. Name

13. Birthplace

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal, Which?)

Date thereof

(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Data rec'd by registrar)

Registrar

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State

County

City or town

Washington - D.C.
(If outside city or town limits, write RURAL and give nearest town)

Street No.

5745 - 13th St. N.W.
(If rural, give LOCATION)

2. (a) If veteran, name war

3. (b) Social Security Number

MEDICAL CERTIFICATION

20. DATE OF DEATH

Sept - 11, 1946 at 8:30 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Sept 9, 1946 to Sept 11, 1946
and that I last saw him alive on Sept 11, 1946

Immediate cause of death

Hypertensive encephalopathy

DURATION

3 days

Due to

Due to

Other conditions

Generalized arteriosclerosis2 years

(Include pregnancy within 8 months of death)

Major findings of operations

Autopsy results

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide

Date of

Where did injury occur?

(City or town)

(County)

(State)

Injured at home, farm, industry, public place (where?)

Means of injury

Injured at work?

23. SIGNATURE

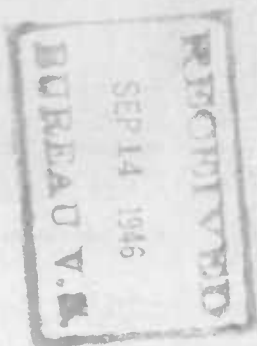
Daniel B. Washington MD
M. D. or other

Address

6234 Ga Ave N.W.
Wash. D.C.

Date signed

9/11/46



PLEASE WRITE PLAINLY, WITH UNFADING INK. Supply every item of information carefully. The correct age is especially important. Physicians: please write the causes of death clearly and legibly.

MARYLAND STATE DEPARTMENT OF HEALTH

2411 N. Charles St., Baltimore (131-2)

CERTIFICATE OF DEATH

09174

Reg. Dist. No. 214

1. PLACE OF DEATH:

County MontgomeryCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)How long in above place of death? 1 year

Hospital, institution, or street address where death occurred:

How long in hospital or institution?

2. USUAL RESIDENCE (HOME) OF DECEASED:

(For newborn infants give residence of mother)

State MD County MontgCity or town Silver Spring
(If outside city or town limits, write RURAL and give nearest town)Street No. 1203 Braddock Rd
(If rural, give LOCATION)2.(a) If veteran, name war 2nd

3. (a) FULL NAME

Edwin T. Yeabower

3. (b) Social Security Number

✓

4. Sex

M

5. Color or race

W

6.(a) Single, married, widowed, or divorced

Single

6.(b) Name of husband or wife

7. Birth date of deceased (mo., day, yr.) Aug 18 1915

8.(c) If alive, give age _____ years

8. AGE:

Years

Months

Days

If less than one day

7169

hrs.

min.

9. Birthplace

Wash. D.C.
(Town, county, and state)

10. Usual occupation

Retired

11. Industry or business

FATHER

12. Name

13. Birthplace

MOTHER

14. Maiden name

15. Birthplace

16. Informant

Address

17.

(Burial, cremation, or removal. Which?)

Date thereof

Sept 20, 1946
(month) (day) (year)

Cemetery or crematory

Location

18. Funeral director

Address

19.

(Date rec'd by registrar)

19.

46

Josephine M. Schaeffer
Registrar

MEDICAL CERTIFICATION

20. DATE OF DEATH 9/18/46 19 46 at 5:00 P.M.

21. I CERTIFY that death occurred on the date above stated; that I attended deceased from

Post mortem 19 _____ to 19 _____

and that I last saw him _____ alive on _____ 19 _____

Immediate cause of death Urasmia

DURATION

Due to

Chronic Interstitial
nephritis

Due to

Severe Arterio Sclerosis
Right Hemiplegia

Other conditions

(Include pregnancy within 3 months of death)

Major findings of operations NoneAutopsy results See medical notes later

PHYSICIAN: Please underline the cause to which death should be charged statistically.

22. VIOLENCE: If death was due to external causes, fill in the following:

Accident, suicide, or homicide ✓ Date of _____

Where did injury occur? _____ (City or town) _____ (County) _____ (State)

Injured at home, farm, industry, public place (where?) _____

Means of Injury

Injured at work?

23. SIGNATURE

Samuel Yeabower M.D. or otherAddress 1203 Braddock Rd Date signed 9/18/46

UNITED STATES DEPARTMENT OF JUSTICE

CERTIFICATE OF DEATH

RECEIVED

RECEIVED
SEP 20 1946
BUREAU OF C.